

THE INADEQUACY OF THE DRAINAGE SOMETIMES OBTAINED BY THE ORDINARY MYRINGOTOMY IN ACUTE OTITIS MEDIA AND A METHOD OF OVERCOMING THE DIFFICULTY.*

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Four years ago I was called to attend a gentleman of over 65 years of age, who was suffering at the time, and had been suffering for a number of weeks, from a virulent type of acute purulent otitis media. He was also afflicted with diabetes mellitus. Previous to my being called to attend him, he had been under the care of two of my confreres, and had been seen by a third in consultation. All had agreed that a mastoid operation was imperative. The patient and his regular medical adviser refused their consent as, in their opinion, the proposed operation, because of the patient's diabetic condition, involved a much greater danger than that which was to be feared from the possible further extension of the aural disease.

On examination of the involved ear I found the external auditory canal stenosed to some extent, the upper posterior cutaneous canal wall sagging and the drum membrane bulging, very thick, and edematous. In the mid-posterior portion of the drum membrane was a small teat-like perforation, through which the pus escaped from the tympanic cavity with difficulty. Tenderness of the mastoid process and some edema of the overlying tissues were present. I agreed with those who had previously taken care of the patient that a mastoid operation seemed to be the only procedure that was logically called for; but, as neither the patient nor his physician was willing that this operation should be performed, there remained nothing for me to do but to establish good drainage from the middle ear through an opening in the drum membrane. And here I should state that paracentesis of this membrane had already been made on at least three different occasions before I saw the patient, and mine, therefore, made the fourth. The incision which I made was very extensive, beginning under the anterior fold of the drum membrane, and extending around the circumference of the membrane, to and through the posterior fold and through the sagging portion of the canal wall.

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On the day after I had made this incision the drainage was free, but on the following day I found that the perforation, because of the edematous condition of the drum membrane, had so nearly closed that the purulent secretion could no longer escape freely. I then decided that an opening of a different nature would have to be made in the drum membrane. It seemed to me that nothing short of an excision of a fairly large portion of this structure would afford an opening of the desired size and of the desired degree of permanency; and such an excision I made by removing the lower and middle posterior portion of the drum membrane with the aid of Hoffman's middle-ear punch forceps. The results were very satisfactory. The discharge, which was profuse, escaped very freely, and it was found very easy to bring into contact with the inflamed mucous membrane of the middle ear such remedial solutions as have the power of thoroughly cleansing and of stimulating the parts.

After the lapse of a few weeks, the patient was able to leave for Europe; the discharge at this date did not exceed a few drops during the twenty-four hours and the perforation was no larger than a mere pin-hole. I later learned that the discharge had stopped before he landed in Europe.

In common with my confreres, I have seen cases of acute purulent inflammation of the middle-ear complicated with mastoiditis, in which all the classical symptoms of the mastoid complication were present in a most pronounced form, in which an operation was advised and even urged, and in which the patient, after refusing to submit to the proposed operation, had ultimately recovered without such interference; but in all the cases of this character that have come under my observation, the discharge, though profuse, has had a free exit through an opening in the drum membrane, which structure, however, was not markedly edematous. On the other hand, in the case which I have just briefly narrated, the edema was so marked that a simple incision gave vent to the retained inflammatory products for a short time only; thus necessitating the adoption of some measure which would establish, for a longer period, a much broader outlet. The procedure which I have described above is the only one, so far as I can see, that offers a reasonably strong prospect of furnishing such a material increase in the diameter of the drainage outlet, viz. an opening of about 3x4 mm.

In the four years that have elapsed since this patient was under my care, I have had twenty-two cases of a similar character, i. e.,

cases in which the edematous swelling of the tympanic membrane was so great as to interfere seriously with drainage from the middle ear and to render abortive every attempt that I made to improve the condition by merely incising (no matter how extensively) that membrane. In all of these cases I resorted to the use of Hoffman's middle-ear punch forceps for removing a portion of the drum membrane, and in eighteen of the cases recovery took place without the necessity of opening the mastoid cells. Furthermore, as regards these eighteen cases, I feel quite confident that, if I had not resorted in each instance to this method of draining the diseased middle ear, the mastoid operation would have eventually become imperative. I might add that in only one of these cases did the perforation in the drum membrane fail to close.

In conclusion, permit me to emphasize the fact that I advocate the adoption of the method herein described only in cases in which it becomes evident, after the lapse of a reasonable period of time, that the usual myringotomy, because of the agglutination of the edges of the incision, can not be trusted to furnish the needed freedom of drainage.

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The Physio-pathologic Relations Between the Hypophysis and Various Chronic Affections of the Naso-pharynx and the Sphenoidal Cavities. CITELLI, *Ztschr. f. Laryngol., Rhino u. ihre Grenzgeb.*, Band 5, Heft 3, 1912, p. 513.

The writer found in five cadavers, where adenoid vegetation was present, hypersecretion and hyperplasia within the central hypophysis; the latter changes in the hypophysis were missing in cadavers where adenoids were not present. In adenoids and other affections of the naso-pharynx as well as in diseases of the sphenoidal cavities, clinically a psychic symptom complex of impairment or loss of memory, aprosexia, intellectual torpor and somnolence is frequently met. These symptoms probably originate in the hypophysis, since the latter, in the presence of a congenital or acquired disposition, may be pathologically influenced by affections of the naso-pharynx and the sphenoidal cavities. Treatment of the hypophysis (pituitin tablets) alone or combined with local or operative treatment of the conditions mentioned above will alleviate these symptoms.

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