

**A CASE OF PANSINUSITIS ON ONE SIDE WITH TIC  
DOULOUREUX ON THE OTHER; NO OPERATION:  
NECROPSY: UNUSUAL FINDINGS.**

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On October 6, 1916, I was asked to see Mrs. J. N., at the Neurological Institute in the service of Dr. Joseph Collins. She was a widow, 66 years old, of Swedish descent, family history negative. The patient was a large woman, weighing 240 pounds, had always been very active, and gave no history of illness excepting severe colds each year, and that she had polypi removed from the nose ten years ago.

The present illness dated from an onset of pain in the left side of her face last February. It became very severe and prostrated the patient, and the various doctors whom she consulted gave her little or no relief. The trouble continued with intermissions. In August she took a long automobile ride to the Adirondacks. On this occasion she acquired a severe cold, and from then on the pain in her face became much worse, necessitating her going to bed. Then she was brought down to Albany to the home of her married daughter, where she consulted Dr. Elting, and several other physicians. During a period of about six weeks she received various treatments there, including vaccine, after which she returned home to Brooklyn. Her physician in Brooklyn then gave her two injections of alcohol, one over the left eye, and one in front of the left ear. These only made the pain more severe, and she finally came to the Neurological Institute on October 2nd, where I saw her a few days later.

Her appearance was most dejected, she was groaning with pain, breathing through her mouth, and constantly holding her head; when her hand was removed from her head, she held the left eye shut. She had lost about 40 pounds in weight, and her flesh was soft and flabby. She described the pain as "a tearing pain" in the back of the left eye, and all over the left side of the head. She also complained of a numb area underneath the left eye, which at times became swollen and very cold. On examination I found the head very tender to the touch all over the left side, especially above and below the left eye and in front of the left ear. The least pres-

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sure over the antrum, the malar prominence, the frontal bone, and the anterior part of the temporal bone caused the most excruciating pain. Examination of the nose showed large roomy nostrils, the left side being clear but containing some pus; the right side was completely occluded with polypi, and a small amount of pus. The throat was surprisingly normal. The teeth were all gone, excepting the lower incisors and the canines, which did not appear to be in a very healthy condition. The ears were not involved.

There was complete paralysis of the left external rectus muscle, which had developed in September, just after the alcohol injections. The pupils were equal. The fundi of the eyes were reported normal.

Transillumination showed the left frontal sinus clear; the right, dark; the left antrum, fairly clear; the right, dark. The left pupil showed distinctly; the right did not.

This seemed to indicate that all the trouble was on the right side, although the symptoms of pain, tenderness, and the paralysis of the external rectus were on the left side. On account of diplopia, she had learned to keep the left eye shut.

She was referred to Dr. Caldwell for skiagraphs of the sinuses, which confirmed these findings, and showed that there was a pansinusitis of the right side, but revealed nothing on the left side or in the left orbit.

Dr. Collins considered that she was suffering from two conditions: the pyogenic infection of the right sinuses, and arterial sclerosis with tic douloureux on the left side; and, furthermore, that nothing could be done for the latter condition until the pus infection on the right side was relieved. He therefore requested me to do a right-sided radical Killian operation, and for this purpose she was removed to the Manhattan Eye, Ear and Throat Hospital on October 10. After further deliberation, however, and noting the patient's weak and enfeebled condition, the question arose whether we were justified in operating on such a patient with a decided arterio-sclerosis, a blood pressure of over 200, and a right-sided pansinusitis, with any hope of relieving the symptomatic tic douloureux on the left side. It was decided to postpone operation and to keep her under observation, and in the meantime to pursue further investigations.

A blood examination showed 90 per cent hemoglobin, 4,800,000 red blood cells, 10,000 leucocytes; no abnormalities in the red blood cells; the differential count showed 21 per cent small mononuclear lymphocytes, 72 per cent polynuclear neutrophiles, 5 per cent large

mononuclear leucocytes, and 2 per cent mast cells. In differential blood counts taken for a number of days the relative percentage remained about the same, but the leucocytes ran up as high as 14,000.

The temperature did not run above 99.5; the pulse varied from 68 to 88; the respiration remained about normal; the blood pressure, from 150 to 210.

The urine, while usually normal, at times showed decided traces of albumin. The amount passed in twenty-four hours varied from 20 ounces plus to 45 ounces plus.

Blood and spinal fluid Wassermanns were negative.

Dr. Hutton, the attending physician, was asked to see her. He found her chest and abdominal cavities practically negative. Her reflexes also revealed nothing. Dr. Hutton suggested having her blood examined for urea, uric acid, creatin, creatinin and carbon monoxide. This was done by Dr. Dwyer, without finding any marked abnormalities except a slight increase of the blood content of creatinin. The pheno-phthalein examination test previously done at the Neurological, was also made and revealed only slight variation from the normal.

Aspiration of the right nostril yielded a fair amount of pus; this, she thought, made her head feel somewhat easier.

While these various tests did not diverge far from the normal, she nevertheless presented the appearance of a person so profoundly ill that I was reluctant to do a major operation. On October 14 I asked Dr. George Brewer, consulting surgeon of the hospital, to see her. He was of the same opinion.

On October 18, under local anesthesia, a number of large polypi were removed from the right nostril, and later aspiration was again done. She left the hospital on October 22, going home to Brooklyn. I kept in touch with the case, and when the patient died, just four weeks later, on Sunday, November 19, asked and obtained permission for a cranial necropsy.

I was fortunate in locating Dr. James G. Dwyer, and together we opened the cranium and removed the brain. Dr. Dwyer's report is as follows:

"The examination was limited to the skull. When the calvarium was removed, the dura was found to be thin and adherent to the bone. There were no evidence of meningitis, except in so far as the adhesions of the dura signified an old slow process, probably secondary to pressure. The brain itself had quite a normal appear-

ance, save for the profound atheroma of the blood vessels, especially at the base of the brain.

"The ethmoid sinuses on the right side were quite full of inspissated pus resembling cottage cheese. The right frontal sinus was full of liquid, creamy pus. The sphenoids were continuous and full of inspissated pus enclosed in a membranous sac which did not open into the nose. The left frontal sinus was clear. The left ethmoid sinuses were quite full of pus and there was an opening through the outer wall into the left orbit, and in the left orbit was found a collection of thick pus which bathed the nerves and vessels. There was no exophthalmos of either eye. There were openings from the left ethmoid directly into the left antrum and the latter was full of pus. Its posterior wall was broken down, and this allowed the pus to bathe Meckel's ganglion.

"Cultures of the pus showed pure *staphylococcus pyogenes aureus*."

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### LARYNGECTOMY FOR EPITHELIOMA.

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Mrs. A. S., a widow, was admitted to the service of Dr. Purdy H. Sturges at the Methodist Episcopal Hospital in Brooklyn, January 14, 1917, complaining of dysphagia and spasmodic cough. The cough was worse at night or when lying down. It may be of interest to state that the patient dated the beginning of her symptoms to 1892, twenty-five years ago, and stated that the difficulty in swallowing and cough had been gradually increasing in severity since then. She had not, however, previously consulted a physician.

Physical examination on admission revealed a cauliflower growth, in size about one and one-half centimeters in its greatest diameter, involving and projecting from the right arytenoid posteriorly, accounting for the dysphagia, and also extending across the median line toward the left arytenoid. Both vocal bands were apparently normal. There was no involvement of the ventricles. There was no hoarseness. There was no involvement of the cervical glands.

It was decided to remove a portion of the growth for microscopical examination and diagnosis and this was done at once under cocaine anesthesia and suspension. The pathological report showed the growth to be a squamous-celled epithelioma.