

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.

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DISCUSSION.

DR. LYNAH 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.

Dr. Yankauer then asked Dr. Lynch whether the portion of the table-top which projected did not interfere with the shoulder and prevent the patient from lying flat on the table. The instrument which Dr. Lynch had shown as his perfected instrument seemed to possess some very decided advantages and he intended to get one and try it.

Dr. IMPERATORI asked whether the majority of the cases were examined under cocain or general anesthesia. How about pressure on the cricoid? How about cases where there is much infiltration? Regarding malignant or tubercular cases? Does the Doctor consider them easy to suspend or not?

Dr. ROSS H. SKILLERN said that he had come all the way from Philadelphia to hear Dr. Lynch and had certainly not been disappointed. He had often wondered how one could do these operations, but it was easy now to see how they could be done with the enormous amount of space which Dr. Lynch gets as compared with Killian's instrument. Another important advantage was the wings on the side. The latest model of spatula from the other side has these two movable wings on it. He had been fortunate enough to get one, but found that they are not necessary at all, as Dr. Lynch had said. The fixed wings are what is needed, for the tongue comes down and it is not necessary to lift the wings in a straight plane. All we need is the groove in there. As far as the spatula was concerned, he had had no experience with it, but had used Killian's retractor or elevator. That you can put in afterward, and lift up, and it has been very satisfactory.

Instead of Dr. Lynch's table, he had been using Killian's table with the head-piece, which can be tipped, and so lowered or raised, and the whole table can be thrown into different planes. He was also accustomed to put the patient in a little different position. The patient was held under the back of the head with the gag in position, and steadied in the median line with the right hand, the assistant controlling the other gag and the lamp. Then the instrument is hung up, and the operator sits down on the stool, so that he is sitting up straight with his eyes on a direct line with the patient's larynx.

Dr. LYNCH, replying to Dr. Yankauer, said that the platform had not gotten in the way many times. On one or two occasions it had done so. The shoulder rests on it a little, but after the case is suspended it does not seem to make any difference in obtaining a view of the larynx. Occasionally it might have something to do with holding the head straight. That was the main trouble, to have the assistant hold the head in the proper position.

As far as anesthesia was concerned, it was much as you would select any other operation under local or general anesthesia. The main thing is to obtain relaxation. If you can secure relaxation under local anesthesia, well and good. If not, use the general anesthesia. Of course it is a question whether general anesthesia is the right thing with some forms of laryngeal obstruction. He believed that formed one of the contra-indications for general anesthesia, for if the patient must depend on his extraordinary muscles of respiration, the moment he is anesthetized they must stop. On the other hand, he had suspended children with almost complete obstruction of the larynx from papilloma and they had no dif-

ficulty. Under cocain he had demonstrated for an hour and twenty minutes. This was in a young negro. He had used suspension with both men and women, white and colored, under cocain, and in many cases it was as satisfactory as under general anesthesia. In the cocain cases, where there is any work to be done, he usually gives scopolamin and morphine beforehand, and then cocainizes the uvula and posterior pharyngeal wall and drops a few drops in the larynx. A 25 per cent solution of cocain in alcohol, gives a deeper anesthesia than 10 per cent. At the same time, with a 25 per cent solution you cannot keep the patient from crawling, if that term might be used. The young negro patient who had been referred to had a very flexible neck and ideal teeth. He was given morphin and scopolamin beforehand, and was not frightened by the procedure. We took all the time that was necessary, and when we got him into the position to make any pressure he simply raised upon his back and crawled up on the table. He was then put back on the table and strapped down and held there. It was explained to him that this was not to chastise him but was necessary to help him out and keep him from taking ether, so he was persuaded. It was very easy to see the anterior commissure.

Replying to the other question, Dr. Lynch said that he did use pressure on the thyroid cartilage sometimes in order to get a better view of the anterior commissure. Occasionally he was not able to see the anterior commissure. In most instances he was successful in doing this, but there are times when it is probably impossible to bring it into view. He made an attempt to get as good a view as possible, and sometimes made a little pressure to bring it into better view. On one occasion he had to steady the larynx from side to side in deep dissection of a malignant growth in the anterior commissure. There was a great deal of difficulty in keeping the larynx absolutely still, and he was compelled to hold the thyroid cartilages to keep them from moving from side to side. That little manipulation helped very nicely. Of course, the question of whether or not it is suitable at all for malignant growths will have to be determined. So far, he has removed six malignant growths from the interior of the larynx, and in all cases had been able to surround the malignant site by healthy tissue,—and there had been no recurrence. The oldest case operated upon will be three years in September. Dr. Lynch said that he had seen this patient just before leaving, and there had been no recurrence. The other cases were under a year, and in two cases there had been recurrence and they had had to submit to other laryngeal operations.

From any case of intrinsic malignancy, he would have some question whether operation was justifiable or not; and if there was any doubt of its not being thoroughly intrinsic he would not attempt it under suspension if the growth extended down under the crico-thyroid membrane. After the patients were suspended two of the cases that were prepared for removal by this method were taken down without being touched, for when the patient was suspended, the vocal cords spread, and the light put down, it was seen that the tumor extended down beneath the vocal cords to a greater extent than could be followed by the mirror or than had been suspected, and it was feared that the tumor had become extrinsic. Both cases were taken down and total laryngectomy was performed.

DR. IMPERATORI asked what type of cases Dr. Lynch considered difficult to suspend.

DR. LYNCH replied that the ones with which he had had most trouble were muscular men with long necks. The teeth did not seem to have much to do with the case. All children suspend very easily, but the adults give the difficulties. He had not yet suspended a thousand cases, and could not just limit the cases. One patient operated upon for a thyrotomy had a big scar and his larynx was bound down tight and seemed to be unusually long—in him suspension was so far impossible.

DR. EMIL MAYER asked Dr. Lynch who made his instruments.

DR. LYNCH replied: McDermott.

Oil-Ether Colonic Anesthesia in Surgery of the Upper Air Passages.

DR. B. J. T. GWATHMEY (by invitation).

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DISCUSSION.

DR. CHARLES BASKERVILLE (by invitation) said that he could not add anything to the subject except to say that whereas ether boils at a temperature below the body temperature, it is interesting to know that we can combine ether with oil and place the solution in the body, where the temperature is above the boiling point of ether, and yet have the ether come out of the oil at a steady rate, easy to regulate. This had been determined in our experiments at the City College.

DR. ARROWSMITH said that in his experience of some 230 anesthetics by this method he had never seen a single adverse symptom, and it had been of the greatest possible comfort to him in work upon the air passages. There had been some failures to anesthetize, but that was due to lack of proper preparation of the patient. If the patient has been properly taken care of beforehand the anesthesia has always been satisfactory, and there had never been any untoward symptoms. Any laryngologist who had used this method could appreciate the relief and freedom from all interference by the anesthetist,—the entire sense of freedom with which the operator can go about his own work. Tuberculosis cases especially do very much better under colonic anesthesia than with respiratory anesthesia. Another important advantage was that the buccal and tracheal secretions are not nearly so profuse. The elaboration of the technique by Dr. Gwathmey was one of the greatest benefits that he has known for a great many years in this department.

DR. GWATHMEY, in closing the discussion, said that he had nothing to add except to emphasize what Dr. Arrowsmith had touched upon. He had been told by a physician who had a very large experience with tuberculous patients that if they were given ether by inhalation they usually died within six months and that as soon as he heard of this new method of giving ether it appealed to him, and that he approved of it heartily after having seen the results of the administration in one or two cases.