

CONGENITAL BONY ATRESIA OF THE POSTERIOR NARES; OPERATION, PARTIAL RESULT.*

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Miss A., aged 21 years, entered the Emanuel Sisterhood Polyclinic on Oct. 8th, 1903, with the following history: She is one of seven children all small in stature but in good health. Mother living and well; father a somewhat dissolute man, who left his family ten years ago. Since childhood patient has been unable to cleanse the left side of the nose by blowing and the discharge is so copious that she uses eight handkerchiefs in a day. She has visited several clinics where the surgeons with but a cursory examination told her she had a growth at the back of the nose. The mother being illiterate, apathetic and unintelligent, it was impossible to get a history of patient's infancy, viz.—difficulty in suckling, breathing, etc.

The nervous phenomena usually found associated with adenoids and most naso-pharyngeal obstructions were not clearly marked; the typical choking spells of the night and reflex bronchial asthma being absent. The mouth-breather's appearance, the so-called "adenoid face," is not present, but one could see at a glance that some interference with nasal respiration existed.

Status Praesens. The patient is small of stature, being only four feet nine inches tall and she is the shortest in the family. I find her well nourished, but poorly developed; the chest, in particular, showing the arrested development.

Asymmetry of the two sides of the face is quite pronounced, the measurements being taken from the external palpebral canthi to the center of the chin. The left naso-labial fold is decidedly less apparent than the right, giving the former side of the face a somewhat flabby appearance. The nose is small, while the play of the left ala during respiration is naturally missing.

Examination of the mouth shows the hard palate to be rather high and very narrow, no difference in the height and development of the alveolar ridges being present. The smallness of the parts caused the only real difficulty in posterior rhinoscopy as the pharyngeal reflex was diminished. The vault of the pharynx is free of adenoids, the mucous membrane smooth and pale.

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The choana on the right side is negative; on the left appreciably smaller, the free end of the bony septum being deflected from the median line to this side, a condition which in itself is rare. I could readily see and probe the bony wall obstructing the left posterior nares which lay anterior to the end of the vomer, the posterior vertical and horizontal plates of the os palatum, constituting this a case of the second class or intra nasal atresia. The left os tubæ is free and with but little difficulty was catheterized from the opposite side of the nose.

Examination of the anterior nares showed hypertrophied turbinates on the right side with a deflection of the septum to the left. The left, the interesting side, was full of particularly tenacious mucus and as attempted washings invariably caused the patient headache, I freed the nose with pledgets of cotton, using 43 at one sitting. The septum was found bent vertically and with an antero-posterior convexity to this side a horizontal ridge on a level with the inferior turbinal body forecasting an agreeable operation. The turbinates were atrophied and cocaine with adrenalin diminished their volume but little. The floor of the nose under about the center of the inferior turbinate was scooped out, forming a bony cul-de-sac, the posterior ascending wall being continuous with the obstruction to the naso-pharynx. This partition was covered with the mucous membrane of the nose and to the probe appeared quite hard. On palpation with the finger in the naso-pharynx and a probe in the nostril, I was led astray as to the probable thickness of the bone. The piece removed later by the trephine proved 16 m.m., approximately $\frac{5}{8}$ th of an inch thick, or about double what I had judged it to be.

No shadowing was evident on transillumination through the mouth and the patient perceived the light equally well with either eye. By placing a small pea lamp in the naso-pharynx and examining the left anterior nares in a darkened room, it was found that the obstruction was evidently too thick to allow the passage of light.

Both ear drums were found retracted with good hearing on either side, the left was not less acute than the right. The sense of smell was absolutely nil on the left side, an atomizer being used, proving that the end filaments of the olfactory are atrophied through non-usage. On the right side it appeared hyper-sensitive. Her sense of taste proved acute and her speech, though nasal in character, was less so than one generally finds in adenoids.

Operation under narcosis was suggested, but patient absolutely refused to take an anæsthetic.

On Oct. 17th, the left inferior turbinate was removed which gave a good view of the obstruction with the exception of the septal por-

tion, that being hidden, owing to the antero-posterior convexity of the septum. Three days later I thoroughly cocaineized the obstruction on either side and with a very long trephine, driven by a relatively powerful motor, drilled a hole directly through the center. The patient was exceptionally brave and did not seem to be in much pain. My efforts thus far were amply repaid when I saw the look of surprise and exultation on her face as she blew the left side for the first time in her life. Her emotion was extreme and ended in an hysterical attack. The bone, as I mentioned before, was $\frac{5}{8}$ th of an inch thick and ebony hard. The bleeding was rather profuse but at no time uncontrollable. I was not able to pass a strip of gauze through the canal as its small size and length made this impossible. The nostril was packed with gauze and the patient told to return the next day. She suffered no secondary hemorrhage and no pain in the nose but the upper teeth on the left side were extremely sensitive. Two weeks later a second hole was drilled a little above and internal to the first, the patient giving signs of great suffering. I had her report at regular intervals, as I wished to watch the course of healing and see whether the tendency to closure was very marked. From its rapidity I hoped to gain a hint as to future operative interference and prognosis.

On Nov. 21st she complained so bitterly of pain that it was impossible to proceed, and a general anæsthetic was forcibly urged, but more forcibly declined. I saw her again on Jan. 22, 1904, and found that the openings were gradually closing but her general condition was greatly improved. The canals were lined with granulation tissue and a probe passed readily into the naso-pharynx. The copious discharge had stopped and she was very comfortable. She could still blow the left side but it was difficult to inspire through it.

Unfortunately I was not permitted to proceed as the operation under cocaine was too painful and patient's antipathy to chloroform still existed. She is very pleased over the result and probably wishes to leave "well enough alone," but when the opening has closed, I expect to have her back.

I have purposely omitted a rehash of the literature as those interested in the subject can find a most able and exhaustive article by Dr. R. Kayser in Prof. Paul Heyman's Handbook of Rhinology.

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