

AFFINITY BETWEEN ATROPHIC RHINITIS AND TUBERCULOSIS.

BY M. CABOUCHE.

Two patients were shown suffering from pronounced atrophic rhinitis, accompanied in the one case with lupus of the nose externally and internally, and in the other by laryngeal and pulmonary tuberculosis.

H. CLAYTON FOX, *trans.*

Abstracts.
NOSE.

Lothrop, Oliver A.—*Some Observations on the Late Results Obtained by the Submucous Resection of the Nasal Septum.* "Boston Med. and Surg. Journ.," May 12, 1910.

Out of 254 patients only fifty-nine reported two years after operation. The author concludes that the method is beneficial in almost every case, but to ensure this it must be thorough and complete. It should not be attempted until the nose has attained full development. (There were eight children in the series; five were thirteen years, the remaining three were ten, nine, and seven respectively. Results do not appear to have been good, and Lothrop thinks the depression of the tip of the nose is due, not to insufficient support from too little cartilage, but to a retarded growth of the remaining cartilage while the bony parts develop normally.)

Macleod Yearsley.

Hajek, M.—*Mucocele of the Sphenoidal Sinus causing Optic Neuritis; Operation; Cure.* "Monats. f. Ohrenh.," Year 44, No. 3.

Having with commendable brevity passed the condition of mucocele of the nasal accessory sinuses in review, Hajek draws attention to the fact that whilst it is comparatively common in the ethmoid cells and frontal sinus, there is still some dispute as to its existence in the maxillary antrum, and rhinological literature affords no example of the sphenoidal cells being affected in this manner. It is for this reason that he publishes the following account:

A married woman, aged forty-seven, consulted him on October 15, 1909, complaining of an unpleasant smell in her nose, headache, chiefly on the left side, since last July, and also from about the same time a steadily increasing loss of sight in the left eye.

Examination revealed a condition of advanced atrophic rhinitis with crusts, which itself demanded intra-nasal treatment before any further investigation could be pursued. Meanwhile an ophthalmic surgeon reported that there was optic neuritis on the left side combined with loss of all sight except mere perception of light, the right eye being normal. In addition the X-ray specialist stated that the left sphenoidal sinus "contained no air," and that under the circumstances this area should be explored as being the possible cause of the trouble.

In ten days' time the nose was sufficiently clean for further examination, and inspection disclosed the following condition: The septum is slightly deflected to the right; both inferior turbinals are markedly atrophied, the right middle turbinate body being similarly affected in its whole extent. On the left side the middle turbinal is atrophied only in its anterior part, whilst posteriorly it appears to spread out into a diffuse, quite smooth body completely shutting off the hinder portion of the olfactory cleft and engaging the septal wall. The probe, however, does not show that this tumour is distinct from either the middle turbinal or the septum, and weak adhesions can be detected in both directions. The surface appeared bony everywhere except in one spot which was elastic to pressure.

Under cocaine this soft spot was broken down with a "hook," when immediately a discharge of sero-mucous material took place about a drachm in amount.

The whole of the anterior wall of the left sphenoidal sinus, as it was then undoubtedly proved to be, was subsequently broken down. The interior appeared perfectly healthy.

The patient reported an almost simultaneous cessation of the headache from which she had continuously suffered during the past few months, and within half an hour after the operation she found she could distinguish objects with the left eye. By November 16 the optic neuritis had completely subsided and the vision of the left eye was as good as that of the right.

Hajek discusses the ætiology of the case and the manner in which the optic neuritis was produced, and concludes with a few words on the diagnostic value of radiography in sphenoidal sinus disease by quoting a note from Dr. Schüller, the X-ray specialist referred to above. "Under normal circumstances, that is, when containing air, the sphenoidal sinus appears deep black with a sharply outlined posterior boundary. Should it not contain air it stands out in strong contrast with the air-cells of the ethmoid immediately in front of it. The localisation of the disease to one or other side is determined either by associated clinical symptoms, such as neuralgia or optic neuritis confined to one side, or by an antero-posterior view in addition to that taken from the side, accompanied with elimination of the ethmoid as a possible factor in the production of the shadow (by intra-nasal inspection). These and further details on the subject are not yet published, but I hope by the end of the year to be able to make them known."

Alex. R. Tweedie.

Turner, A. Logan, and Lewis, C. J.—*A Further Study of the Bacteriology of Suppuration in the Accessory Sinuses of the Nose.* "Edinburgh Med. Journ.," April, 1910.

In this paper the authors publish the results of an investigation into the bacteriology of nasal sinus suppuration. Forty-three suppurating antra, seventeen cases in which antrum and other sinuses were involved, six frontal sinuses, one frontal mucocele, one orbital abscess, one antrum which was full of mucoid secretion, and one dental cyst formed the material investigated. The paper is too statistical to be satisfactorily abstracted. The conclusions of the authors are the following:

(1) That sinus suppuration is not caused by any one particular micro-organism.

(2) That while bacilli may cause suppuration, we think that pyogenic cocci of various kinds are more often responsible

(3) That four main types of cocci are commonly met with in sinus suppuration, viz. pneumococci, streptococci, staphylococci, and diplococci of the type of *Micrococcus catarrhalis*.

(4) That the following groups of bacilli are frequently met with in sinus suppuration: (a) *Bacillus coli* and its allies; (b) putrefactive bacteria, such as *proteus* and its allies; (c) dental organisms, such as *Bacillus gangrenæ pulpæ* and *Bacillus necrodentalis*; (d) an obligate anaërobic group, of which prominent members are *Bacillus perfringens* and *Bacillus ramosus*; (e) a diphtheroid group, and (f) *Bacillus influenzae*.

(5) That pus in a considerable number of chronic uncomplicated antral cases contains organisms of dental and buccal habitat, and that in some of these cases it is possible to isolate identical organisms from the pus and from diseased teeth extracted at the time of operation upon the sinus.

(6) That clinical and bacteriological investigations agree in showing that nasal infection of the antrum is more common than dental infection, and that probably about one third of the cases of antral suppuration are due to dental infection.

(7) That while in bilateral antral suppuration the pus from the two antra may contain the same bacteria, this is not invariably the case; we have isolated from one antrum a virulent diphtheria bacillus which was absent from the other.

(8) That in recent cases of sinus suppuration the streptococci were found virulent in 60 per cent., and in chronic cases only 30 per cent. have been proved virulent.

(9) That fœtor is the result of the growth of certain organisms, sometimes of those responsible for the suppuration, and sometimes of those concerned in the decomposition of the products of inflammation. That both aerobic and anaërobic organisms are capable of causing fœtor.

(10) That fœtor may be present in antral suppuration of very recent origin, as well as in chronic cases, and that antral cases of nasal infection, as well as those of dental infection, may be fœtid.

(11) That recent cases of maxillary sinus suppuration (duration in this series two days to three weeks) readily cure by lavage.

(12) That when lavage is practised, whether in recent or chronic cases, it should be carried out through the nasal cavity; the alveolar opening should be abandoned.

(13) That a certain proportion of chronic cases of antral suppuration are cured by lavage, but we cannot determine from the history of the case, the duration of the discharge, or the path of infection which cases may be so healed successfully.

(14) That some assistance in the choice of lavage may be obtained by a preliminary microscopical examination of the cell elements in the discharge and from a bacteriological investigation of the pus.

(15) That the value of cytological examination, however, is minimised by the fact that the inflammatory process causes more advanced changes in one part of the lining mucous membrane of the antrum than in another.

(16) That in those cases in which the discharge shows a relatively small number of lymphocytes, the prospect of cure by lavage is greater than when an excess of lymphocytes occurs (J. M. Darling).

(17) That chronic cases in which no *Streptococcus pyogenes* is found in the pus more readily respond to lavage than those in which the same organism is present.

(18) That when in chronic cases there is an excess of lymphocytes in association with the *Streptococcus pyogenes*, treatment by lavage should not be attempted.

(19) That neither inoculation experiments nor histological examination of the lining membrane of the antrum explains the apparently greater resistance of the *Streptococcus pyogenes* to treatment by lavage.

(20) That failure in treatment by lavage may possibly be due to a deficiency in the patient's protective substances to deal with the streptococcus, and that a specially prepared streptococcic vaccine might be appropriately tried in these cases.

(21) That we have no evidence that any special combination of organisms is responsible for the failure of treatment by lavage.

Arthur J. Hutchison.

Madden, F. C.—*Quiet Polypoid Sarcoma of the Nose.* "The Practitioner," March, 1910.

An interesting paper, with numerous illustrations, on a form of slowly growing sarcoma common among the Egyptian natives. This growth apparently starts as ordinary nasal polypi, which gradually become malignant, involving the entire nose and upper part of the face except the lower lip.

Macleod Yearsley.

Voss, F.—*Sarcoma of the Sphenoid (a typical clinical picture).* "St. Petersburg. med. Woch.," 1910, No. 14, S. 205.

The author reports on four cases of a very unusual type. The patients, of an age from twenty-five to forty-five, suffered from severe headaches; this was followed by the appearance of tumours in the neck high up or along the great vessels, and first on the right side. Either at this period or rather later the naso-pharynx becomes involved; the roof appears to have sunk; it has an elastic feel. In certain of the cases the hearing was affected. The facial nerve was unaffected and no other cerebral symptoms appeared. The most remarkable symptom was the intense headache. The prognosis is bad, for death ensues after about three years. In only one case was a section obtained, and the whole body of the sphenoid was converted into a tumour mass. Medical treatment is, of course, valueless, the only hope would be an early and extensive operation

W. G. Porter.

Voislavsky and Braun.—*Squamous-celled Epithelioma of Antrum of Highmore.* "Laryngoscope," February, 1910, p. 129.

Man, aged thirty-seven, suffering from nasal polypi which were removed. Examination showed typical polypoid tissue.

Three months later, return of unilateral nasal occlusion with some hæmorrhage, marked exophthalmos, œdema and tenderness over superior maxilla. Polypi removed from middle meatus. Frontal sinus filled with pus. Antrum washed out, no pus found. X rays showed shadows in both antra

Killian operation on frontal and ethmoidal performed. Antrum then opened through canine fossa, and found to be full of softish material "like granulation tissue." This was curetted away, and on examination proved to be squamous epithelioma. The facial wall of the antrum was found to be eroded at the operation.

Three months later removal of the superior maxilla was resolved upon and the operation was begun. The soft tissues of the cheek were found to be infiltrated, however, and the operation was not completed.

Dan McKenzie.

Campbell and Rowland (Ohio).—*Acute Pneumococcic Meningitis, with the Report of a Case Secondary to Empyema of the Frontal Sinus.* "Amer. Journ. Med. Sci.," April, 1910.

In the case here reported "the infection evidently passed to the anterior ethmoidal cell from the nose by way of the infundibulum, and thence through the foramen into the frontal sinus." The posterior wall of the sinus was eroded over a small area and the meninges infected from this point. The following points are to be regarded as characteristic of pneumococcic meningitis: (1) It is fatal in 99 per cent. of all cases; (2) the exudate is greenish-yellow and markedly cellular and fibrinous; (3) the increase in neuroglia in the sub-pia and in the cranial nerves; (4) the infiltration of the walls of the arteries with leucocytes and exudate.

Thomas Guthrie.

Freudenthal, W. (New York).—*Endocranial Complications of Nasal Origin.* "Laryngoscope," January, 1910, p. 60.

Four cases are described:

CASE 1.—Female, aged twenty-five. Acute frontal sinusitis; refused to allow removal of middle turbinal. Some weeks later purulent discharge suddenly ceased and intense headache, fever, and œdema of right eyelid supervened.

Operations.—Antrum opened. Frontal sinus opened; pus found in cellular tissue near the outer canthus; posterior wall of sinus eroded, and a subdural abscess containing 2 oz. of pus opened and drained. But symptoms persisted unrelieved. Frontal bone trephined above the sinus; pus again found not only in the subdural space, but also apparently in the substance of the frontal lobe. Death. *No post-mortem.*

CASE 2.—Male, aged twenty-five. Influenzal frontal sinusitis, with swelling and fluctuation over the affected sinus.

Operations.—Frontal sinus opened; bone above and to outer side of sinus discoloured and bloody; this removed disclosed extra-dural abscess. No pus in brain on needling. After this operation patient became semi-comatose. The wound was then opened up and the dura was found to be bulging. Needle inserted into brain struck pus at a depth of 2 cm. Abscess opened and drained. Recovery.

CASE 3.—Patient, aged nineteen, suffering from headache, serous nasal discharge, pyrexia, and general toxæmia. After some days the nasal discharge dried up, and the left upper eyelid became red and swollen, and the patient semi-comatose.

Operations.—Frontal sinus opened and found to contain pus. No improvement followed. At a second operation frontal sinus reopened; ethmoidal cells cleared out and sphenoidal sinus examined with probe. Probe found to pass far beyond limits of sphenoidal sinus into a purulent mass, ? temporo-sphenoidal abscess. Death. *No post-mortem.*

CASE 4.—Alcoholic subject with certain cerebral symptoms and nasal suppuration, relieved for a time by operation on frontal sinus and ethmoid. Symptoms recurred some weeks later, and, after a chronic course, led to death six months after the operation. The author is convinced that the fatal result was due to "regionary metastasis from the frontal and sphenoidal sinuses," but the diagnosis from other brain lesions was not established by *post-mortem.*

Dan McKenzie.