

CORRESPONDENCE.

THE RELATION OF NASAL CONDITIONS TO DEAFNESS.

To the Editor of THE JOURNAL OF LARYNGOLOGY, RHINOLOGY, AND OTOTOLOGY.

SIR,—Every reader will feel indebted to Dr. P. McBride for his excellent article in your August issue; it is not merely instructive as to the past and critical as to the present, but it contains much suggestion for the future.

May I be permitted to make a few remarks upon one of his sections—that relating to the relation of nasal conditions to deafness? It deals with a subject which comes continually before the otologist, and appeals especially to those who believe in what may be called the *preventive future of otology*.

Dr. McBride writes from an avowedly sceptical point of view. May not the whole secret of the relation between nasal conditions and deafness be summed up in one term—*defective nasal drainage*? To this may be added the effects upon the nose of chronic toxæmia, most frequently due to intestinal causes.

The effect upon the middle ear of a badly drained nose is quite simple and straightforward; secretions are hung up in the nasal chambers, undergo such alterations as to render them irritating, and collect in the naso-pharynx, where they act as a continual irritant to the pharyngeal and naso-pharyngeal mucous membrane. The nature of this alteration of secretion, whether microbial or chemical, can scarcely be discussed in a short letter.

The conditions likely to exist in the nose as a cause of defective nasal drainage are, I believe, mostly in connection with the septum. Bad deflections, especially those which result in a narrow crevice on the concave side, can very well hold up secretions. But bad deflections are likely to arrest the attention of the oto-rhinologist more readily than lesser degrees. I do not think that enough importance is given to those slight abnormalities which, lying close to the floor of the nose, show a very narrow cleft in that region.

Another nasal condition likely to lead to middle-ear deafness is the posterior bony spur, which, under certain conditions, may come into contact with the posterior end of the inferior turbinate. Such spurs are very frequently accompanied by enlargement of the posterior end. The latter condition is a common concomitant of septal growths and deflections, even of the minor kinds, and it is quite probable that they are due to the same irritation by altered secretions. When present, the glandular hypertrophy which forms an important part of them results in an augmentation of secretion which is prone to collect in the naso-pharynx, especially during sleep.

Your readers may remember that, in 1914, you were good enough to publish a short note of mine in which I suggested that the accumulation of altered nasal secretions on that side of the naso-pharynx which is lower during sleep, was responsible for determining which ear became first affected.

I have for some time past been consistently employing the Holmes electric naso-pharyngoscope in the examination of patients complaining of nasal and aural symptoms, and I have been much struck by the frequency of signs of chronic irritation of the Eustachian tubal orifices in the

conditions mentioned above. Such signs have given me the clue to appropriate treatment.

The effects upon the nose of chronic intestinal toxæmia also merit more attention than has been accorded to them. Many of the cases of varying turbinal hyperæmia (with or without accompanying septal abnormalities) clear up with remarkable rapidity when the toxæmia is treated. They are really instances of disturbed vasomotor conditions, and are often subjected to the tragedy of galvano-cauterisation.

I am, Sir, yours faithfully,

August 21, 1916.

MACLEOD YEARSLEY.

NOTES AND QUERIES.

PULMONARY SUPPURATION AFTER TONSILLECTOMY.

In the *Interstate Medical Journal* Dr. H. Wessler has published a skiagraphic study of the pulmonary inflammation due to aspiration, which sometimes follows tonsillectomy. He applies the term "lung suppuration" as more accurate than abscess or gangrene of the lung, which describe only a possible phase of the process. At the Mount Sinai Hospital, New York, he has examined with the X rays eight cases of pulmonary suppuration following tonsillectomy. These formed as high a percentage as 28 of all the cases of pulmonary suppuration observed in the same period. In all a general anæsthetic had been administered—a procedure which stands in close relation to the complication. After an incubation period of a few days symptoms of broncho-pneumonia begin. Later, evidence of suppuration—chills, high fever, and purulent expectoration—supervenes. In practically all the cases the sputum was foul at some time or other. This is some justification for the designation of gangrene of the lung, but the latter is a subordinate lesion. The putrefactive organisms usually cause small areas of gangrene, and as these are sloughed out the sputum becomes fœtid. Periods of gangrenous sputum alternate irregularly with others in which there is no distinctive odour. Hæmoptysis is a very constant symptom, and varies from a slight brownish discoloration of the sputum to the expectoration of a pint of blood. Pain is frequent, and due to associated pleurisy. A predilection for the right lung was noted (six of the eight cases), and any lobe may be affected. The physical signs are frequently not distinctive, and are of the least value in diagnosis. As a rule, an area of dulness of varying extent is demonstrable with but few changes in the respiratory sounds, which are frequently diminished. In not one case were there signs of a cavity. There is evidently consolidated and poorly aerated lung, sometimes covered by thickened pleura. In six of the cases spontaneous recovery took place in from six weeks to five months. In one case recovery took place after two years—following excision of carnified lung. The remaining case is still unimproved. Skiagrams show an infiltration of the lung of varying extent. In five cases a cavity was demonstrated, in some with a fluid level which shifted on a change of position of the patient. The shape of the infiltrated area varied; in some a lobar distribution was seen; others gave the impression of a residual infiltration involving only the small portion of a lobe. Unless the lower lobe is involved there is no restriction of the movement of the diaphragm. When present, cavities are easily recognised as lighter areas of circular or elliptical shape within the shadow of infiltrated lung. In two cases they were multiple, and in two located at the hilus. When filled with secretion they may be invisible, but come into view after copious expectoration. The process of cure may be followed by the Roentgen rays. The infiltration gradually becomes less dense and fades at the periphery until it disappears, leaving perhaps a few thickened strands for some time. But clinical cure may be associated with persistence of the infiltration. Whether in such cases recrudescence follows cannot be said.

BOOK RECEIVED.

Throat and Ear Troubles. By *Macleod Yearsley, F.R.C.S.* With 12 Illustrations. London: Methuen & Co., Ltd. Price 1s. net.