A CASE OF SUCCESSFUL RHINOPLASTY IN AN OLD WOMAN.

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MANY writers doubt the expediency of attempting to restore a mutilated nose by plastic surgery, holding that the distressing deformity can be more satisfactorily dealt with by providing an artificial substitute which is retained in position by being attached to the bridge of a pair of spectacles. The sentimental factor in the case, however, counts for much with many people, and will probably always continue to do so.

Mrs. X., aged 72, formerly an obstetric nurse, came under my care at the Sheffield Royal Infirmary in the summer of 1909 for a rodent ulcer of the nose of seven years' duration. It had destroyed the greater part of the cartilaginous framework, but the nasal bones and the skin over them were intact.

She was transferred to the x-ray department, but failing to receive material benefit from a prolonged course of treatment, I decided to excise the ulcer and restore her nose by the Indian method of displacing a flap from the forehead. The result, as will be seen from the accompanying photographs, taken two months afterwards, is remarkably good.

formed the columna and alae nasi respectively. After placing a piece of rubber tubing in each nostril, and anchoring them by sutures to the upper lip, the flap, which included the periosteum, was stitched in its new position. To guard against the effects of subsequent oedema, several superficial incisions were made in its epidermis.

3. The large gap left on the forehead was filled by a piece of the entire thickness of the skin transferred from the side of the chest and sutured to the edges of the wound. Primary union took place everywhere, and, with the exception of a tiny bit at its upper border, the skin graft retained its vitality and natural colour.

Of the various methods of performing rhinoplasty, the one I adopted is probably the best for cases where the destruction is limited to the cartilaginous part

of the nose. The objections that have been urged against it fall under three headings.

First, there is the risk of immediate failure from necrosis of the flap owing to undue interference with the blood vessels in its pedicle; and, in the second place, there is the undoubted tendency to subsequent atrophy of its tissues from the same cause, acting in a slighter degree. These dangers may be largely,

if not altogether, avoided by following the plan I pursued.

A point worth noting is that by separating the periosteum from the underlying bone around the origin of the pedicle it is rendered much more mobile without its blood supply being in any way interfered with. There should be no necessity for subsequent division and trimming of the pedicle.

The third objection has reference to the unsightly scar left on the forehead. My case demonstrates that it may be wholly avoided by employing the Wolf method of grafting a piece of the entire thickness of the skin from the side of the chest wall. I frequently make use of the Wolf graft, and with almost constant success, in operations on the face and neck; and I am quite sure its value is not properly appreciated by the majority of surgeons.

THE INEQUALITY OF THE PAPILOEDEMA IN CERTAIN CASES OF INCREASED INTRACRANIAL PRESSURE.*

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In the first place I will assume that papilloedema is due to increased intracranial pressure. There is in support of this view the facts that the swelling rapidly subsides after a radical or palliative operation for tumour, or on the relief of acute Bright's disease; that the increase of intracranial pressure can be proved by lumbar puncture; and that there are usually other signs of intracranial high tension such as the headache and vomiting of tumour, meningitis, or Bright's disease, the headache and epistaxis of typhoid fever; and in anaemia, when there is sometimes swelling of the disc, there is also swelling of other unsupported parts. I shall endeavour to prove presently that the disc is an unsupported part.

The parts to be considered are the brain and spinal

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cord in their membranes, the optic nerves, and the eyes. The brain is joined to each eye by a direct prolongation of its substance—the optic nerve—and its membranes form a firm fibrous sheath, which is firmly attached to the margin of the scleral opening which admits the optic nerve. This sheath is closed in part by the lamina cribrosa. The eye is enclosed in a firm unyielding case formed by the sclera behind and the cornea in front, and the only weak, unsupported spot is the space above mentioned for the admission of the nerve. The brain, spinal cord, and their membranes are enclosed in an unyielding case formed by the skull and spinal canal, the only opening being for the entrance of blood vessels and the exit of nerves. While the intracranial pressure is compatible with life the brain must receive a free blood supply, so the blood pressure must rise *pari passu* with intracranial pressure, and we have as evidence of this the slow, full pulse; no relief, therefore, can come from the vascular system. The pressure, then, can only be relieved by exudation along the nerves and lymph spaces. The optic nerves are the largest, and are a direct outgrowth of the brain, and therefore they afford a suitable channel for the exuding fluids.

Now according to the laws of hydrostatics, as the brain