PRACTICAL SUGGESTIONS IN CONNECTION WITH THE TREATMENT OF SOME DEFORMITIES OF THE NOSE.

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THE difficulty of keeping in proper position the nasal bones and other nasal structures in cases of recent comminuted and depressed fracture, and also after operation for the relief of deformity the result of old-standing injury or of disease, has been experienced by all practical surgeons. Fifteen years ago I showed to one of our medical societies here a simple appli-

Fig. 1.—Before operation.

ance which I had used with good result in a case of this kind, and since then I have employed the same appliance, slightly modified and improved, in several other cases. The appliance, which I here describe and figure, acts upon the principle of "slinging" the depressed textures in position, and at the same time exercises the proper amount of lateral pressure. It consists, (1) of a piece of sheet lead (Fig. 3, A) formed into an arch with a ledge upon each side, which rests upon the cheeks. The arch should rise higher than the nasal bones when they are brought into proper position, and at the points where the pin is introduced and passes out a notch is made through the ledge up to the base of the arch, as shown in the figure. The sheet lead being pliable allows the arch and ledges to be easily shaped so as to adapt themselves to any case.

(2) Of a fine steel pin (Fig. 3, B). This pin has a fixed head at one end, and the other end is sharply pointed. Two-thirds

of the length of this pin from the sharpened end consists of a fine screw, which allows a movable and rounded nut (Fig. 3, C) to move along it, and so regulate the lateral compression of the lead arch.

(3) A small cap (Fig. 3, D) which can be screwed on to the sharp end of the pin, and so prevent the sharp point from wounding the cheek.

In Fig. 4 is shown the appliance in position.

In cases of recent injury the bones and other nasal textures are first brought into position by external and internal manipulation; the pin is then passed through the base of the nose from side to side at the point which seems best for supporting or slinging the bones, and the lead arch having been fitted on a piece of silver wire is passed round each end of the pin, and when tightened is twisted and secured over the arch so as to

Fig. 2.—After operation.

draw up and sling the depressed bones and their coverings. The movable nut on the pin is now screwed home until the proper amount of lateral pressure to assist in moulding and keeping the nose in good position is obtained. When the cap has been screwed on to the sharp end of the pin the application of the appliance is completed.

In cases of old-standing depression of the nasal tissues from injury or disease, my practice is first to expose the anterior nares by turning up the upper lip, after dividing the mucous membrane, and then to introduce a pair of small bone forceps and separate the nasal bones from their connection with the superior maxilla. In some cases I have nipped across the nasal processes of the superior maxilla, so as to use them also in forming a firmer nasal support. When the bones have thus been loosened the case is treated as one of recent comminuted and depressed fracture, and the pin and arch of lead applied in the manner described after the parts have been manipulated into as natural a position as possible.

In connection with the subject of nasal deformity, I take this opportunity of describing and illustrating a plastic operation which I performed a few years ago in order to cover over an ugly opening resulting from the loss of the entire nose and surrounding textures of the cheeks (Fig. 1). This patient

Fig. 3.

had been subjected to several operations for recurring rodent ulcer, which had necessitated the removal of the whole nose

Fig. 4.

and a large portion of the cheeks. The tissues all round the deficiency exposing the nasal cavities were cicatricial, and could not be used to cover over the gap. As the patient was very anxious to have the opening closed, I performed with

success the following procedure. One flap (Fig. 1 A) was cut from the forehead, and left attached at its upper end. A second flap, B, was cut from the tissues of the upper lip, its base towards the lip was not carried down through the margin, but terminated a little above the position of the coronary artery, and was left attached there, so that the nourishment of the flap was not interfered with. The edge of the opening were then pared, and the two flaps having been separated from their attachments except at their bases, were brought together over the opening and secured by stitches. When the flaps were stitched together the centre of the upper lip was drawn up so as to expose the front teeth of the upper jaw, but when the circulation in the flaps had been thoroughly established a second operation for relieving this was performed by cutting through the lip on each side of the drawn-up portion, and then bringing together the divided surfaces of the lip, as in a case of harelip.

In Fig. 2 the result of this operation, which was entirely successful in closing the opening, is shown. One trouble remained, and it was that the lower flap, having been taken from the upper lip, was covered with hair, but the patient preferred this to the unsightly gap which had previously existed.

INTRODUCTORY LECTURE

ON

TEACHING & LEARNING MEDICINE.

Delivered in the Author's Winter Course of Lectures on the Principles and Practice of Medicine.

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GENTLEMEN,—It is not my custom to give a formal introductory lecture. I am usually in the habit of plunging at once into the subject, for the amount of work that we have to do is so great that it is essential to economise time as much as possible; but this year I mean to make an exception, and before commencing the proper work of the course I propose to direct your attention to the method of teaching which I follow, and to the method of study which I would advise you to adopt.

The subject which we are met to study (the principles and practice of medicine) is, as you know, a very extensive one. It is probably the most extensive subject in the medical curriculum, and it is continually and rapidly increasing. Five-and-twenty years ago, when I graduated, our teachers used to tell us that a hundred lectures on the practice of medicine were insufficient, and we students used to think that the amount of work which the subject required of us was very great. Since then enormous advances have taken place in every department of the subject, more especially in the department of nervous diseases and in the subject of bacteriology, which is of such immense importance, and about which little or nothing was known at that time; and there is every reason to hope that during the next five-and-twenty years at least an equal advance and extension will take place.

After hearing this statement some of you may perhaps be tempted to pity the student of the future, and to congratulate yourselves that you have commenced to study the subject to-day, before this further great development takes place. If any of you reason in that way, I venture to think that you are making a mistake, for although the gross extent of the subject which we term "the Practice of Medicine" will undoubtedly have enormously increased in the course of the next five and twenty years, that very increase will facilitate teaching and learning. Every fresh development and addition to our knowledge enables us to see more clearly the "whys" and "wherefores" of things, to systematise, classify, and intelligently explain the phenomena of disease. In short, with each advance it is possible to make order out of chaos, and to bring facts and phenomena, which before were isolated and disjointed, into intelligent relationship with one another. As our knowledge becomes more certain and more advanced, we need no longer be content with the mere