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LECTURE ON POLYPUS OF THE NOSE,

DELIVERED AT
ST. GEORGE'S HOSPITAL, ON NOVEMBER 2, 1843.
By Sir B. C. BRODIE, Bart.

BEING THE FIRST OF A COURSE OF LECTURES ILLUSTRATIVE OF SOME IMPORTANT PARTS OF SURGERY,
Delivered gratuitously to the Pupils of the Hospital.

GENTLEMEN,—Let me first explain to you very briefly the kind of lectures I intend to give you this season. Now, in the wards of the hospital you see many varieties of disease which you have ample opportunity of studying. But there are many diseases, occurring almost exclusively in private practice, which you cannot see in the wards of the hospital; and I intend, in this course of lectures, to speak to you on those diseases.

The first of these will be polypus of the nose—a disease frequent in private practice, but rare in the hospital.

Under the name of polypus of the nose many affections have been confounded together; but I mean by it simply an excrescence of the Schneiderian membrane, having a peculiar character, which I shall describe hereafter, and being non-malignant. This disease, simple polypus, is of much more frequent occurrence among the higher classes of society than in the others, and is more common in men than in women. It seldom occurs before the age of puberty, though it does sometimes. I have not been able to connect it with any particular habit of body or mode of life. It is common among the Portuguese; a Portuguese physician informed me that it was attributed by them to the snuff which they take being largely adulterated with ground glass. It may be so; the irritation may be a source of polypus; but I have not observed that snuff-takers in this country are more liable to it than others, and I believe that snuff is quite as much adulterated here, quite as much, in fact, as medicine.

Polypus is a tumor generally attached by a thin neck to the Schneiderian membrane, but sometimes by a narrow pedicle, or a long, thin membrane. The membrane which covers it is continuous with the Schneiderian membrane, but differs from it by being less vascular. The surface of the polypus is very smooth; it possesses little vascularity; sometimes you will see vessels burrowing into it. It is gelatinous in density, and appears to consist of coagulated albumen. In some few instances there is only a single one, but more commonly there are two or three, and frequently they are found in clusters, so that you can scarcely count them.

The color, which is an essential point, is pearl-like, or white mixed with brown, of an opal appearance. Soft polypus of this kind I have never seen attached

to the septum nasi, nor to the inferior turbinated bone, nor to any part of the nostril; but it is almost always attached to the cells of the ethmoid bone, occasionally to the superior turbinated bone.

A woman came into this hospital some years ago, when I was surgeon to it, having symptoms indicating polypus in its early stage; she died of another complaint, and, on examination after death, the cells of the ethmoid bone were found distended by a substance similar to polypus.

The *symptoms of polypus* are, in the early stage, merely an unnatural secretion of mucus; a greater desire to blow the nose, which may arise from common catarrh; but, in the latter case, it lasts for a limited period, whilst the mucous discharge from polypus does not subside, which circumstance would make you suspect an incipient polypus.

In other diseases, such as when bone is affected, you have *pain* in the forehead, but there is *no pain* in polypus. The sense of smell is affected; it may be altered merely, the patient fancying he smells offensive odors which do not exist; or it may be destroyed, which is more common; and the sense of taste at the same time is injured, if not destroyed.

These symptoms increase as the polypus gets larger. There is obstruction of the middle meatus of the nose, then of the inferior meatus. Respiration through the nostril is rendered imperfect, and at last the patient breathes only through the mouth; this is troublesome especially at night, because the use of the jaw in the day keeps up the action of the salivary glands; but at night the mouth is always open and dry, and the tongue becomes hard, like a board. There is no difficulty of blowing the nose at first, although afterwards there is, and the mucus is blown down the pharynx.

The progress of these symptoms differs; in some cases they come on within a year, in others not for many years.

Polypus, if neglected, grows larger, and alters in condition, becoming more solid, the base of it almost cartilaginous in density; sometimes it is large enough to hang out from the anterior nares. It is found to vary with the weather, swelling in a moist atmosphere, but drawn up in a dry one; it acts, it fact, as an hygrometer to the patient. The tumor, when pendulous, cannot be mistaken, having a smooth surface and an opal, semi-transparent appearance. It may project backwards into the pharynx behind the soft palate.

In one gentleman I knew, where it projected into the pharynx, it occasioned cerebral symptoms and giddiness from pressure on the internal jugular vein. It seldom happens that you see worse symptoms than these, because persons generally procure the assistance of a surgeon before the case is so far advanced. But there are instances in which the disease is

neglected, and it goes on farther than this; for I remember a man coming into the hospital, some years ago, having formerly had a polypus removed; but when he came in it was of an enormous size, projecting out from the nostril under the skin of the face. The patient, however, died of cerebral symptoms, for nothing was done to the polypus. Upon examination after death, there was effusion in the ventricles of the brain, arising from the immense pressure of the polypus.

I remember also a boy, sixteen years of age, having a polypus of an enormous size, I should say not less than my fist, hanging down at the back of the pharynx, and, on examination with the finger, it could be felt in the mouth; it pushed out the ossa nasi, giving him a very broad nose, which covered half his face. I lately saw a case where polypus caused absorption of the os unguis; it extended into the orbit by pushing forward the os planum of the ethmoid bone. It was removed, and I believe the patient recovered.

Diagnosis of Simple Polypus.—In the early stage it is doubtful, for you cannot see it; but, when it has attained a certain size, it becomes visible by dilating the nostrils with the forceps. You place the patient with his head well back before the window, and hold the nostril open with the forceps; you then see the polypus, and the more easily if the sun shines. If it be large in size, you wish to know how far it extends; then you can tell if it extends into the pharynx by putting your finger into the patient's mouth; if it should extend to the brain you may tell it by the cerebral symptoms.

Treatment.—You have now ascertained that it exists, and how are you to get rid of it? It is not under the influence of any medicines, being quite a local disease. It is not worth while to try them. After the polypus has been removed, I have used local remedies to prevent its return, but they are only useful then.

The best plan is to remove it; and how is it to be done? There are many ways—

1. *By Ligature.*—You will read in the works of old surgical writers of certain kinds removed by ligature. Here is one for example, but this is not a common polypus, in which it is impracticable; and those who proposed to do it never had anything to do with the disease.

2. *Dissection by the Knife.*—This, too, is impossible, as you cannot see it, and when you touch it with the knife the blood will directly flow, so as to prevent your continuing the operation.

3. *The scissors* have been proposed, but with these you cannot see your way sufficiently.

4. *Forceps.*—This may seem a rude way of operating, but it is the best, provided you have *proper forceps*, and know how to use them. The proper forceps will pull away the neck of the polypus.

I remember, when I was first house-surgeon here, I found a pair of forceps, and wondered why I could not succeed with them; they were rough, like a file, at the extremity, the rest of the surface being quite smooth. The whole of the opposite surfaces, however, ought to be quite rough; convex above, concave below, opening laterally, so that it holds the polypus quite tight. They should be pretty strong,

not slender, unless for small nostrils. Here are forceps made with a screw in the handle, having a double worm, so that, when the polypus is grasped, by proper manoeuvring and screwing it tight, there is no danger of its slipping off. The operation may be longer, but it is more certain. In a few cases you will want forceps such as these, which open from above downwards, but they are not often required.

Operation.—The forceps (of course) should be oiled and warmed; the patient placed in a chair opposite the light, with his head thrown well back, the chin elevated; examine carefully the nostril before operating; don't push the forceps at random, but get hold of the polypus as near the base as possible, by introducing the forceps upwards and backwards to the back part of the nostril; be careful to place one blade on one side, and one on the other, and tighten the forceps by means of the screw. The polypus being now well seized, how is it to be taken out? It must not be merely pulled out at once, or it will break off; but it should be first twisted a little to one side, then to another, then gently drawn forwards, then pushed backwards, then twist it again. Having done this a few times, draw out the forceps with some force, and the polypus will come away entire. There may be several others; if there are, repeat the operation. The patient should be directed to blow his nose, so as to bring any others into view; if he cannot do so, you must (without seeing them) endeavour to remove them. There may be, also, a small one jammed in by the larger one, which is brought into view on removing the latter. Having done all this, the patient will blow his nose and say, "Dear me! how comfortable I am; I haven't blown my nose for these two years."

In some cases one operation is sufficient; in others, two, and even three, are required. You should be *tender* in using the forceps; rough usage might impair the cells of the ethmoid bone, or even the cribriform plate. I never saw any harm result from the operation; no inflammation, nor cerebral symptoms, nor erysipelas. Mucous membranes bear more injury than the skin, as in the case of internal piles. In one case hæmorrhage followed, which I easily stopped by plugging the nostril with lint.

In some very old polypi, which become firm and cartilaginous, there is great adhesion to the bone; it is, however, of no importance if you remove a small plate of the bone with it, as it shows that the whole polypus has come away. In these cases I used a peculiar pair of forceps, resembling those employed by ladies for cutting flowers; they are so constructed as to cut at the upper part, having a rough surface below to lay hold of the polypus. These are introduced, and the polypus is shaved off as near to the bone as possible.

Here is another pair of forceps, similar to those invented by Dupuytren for artificial anus; they are, however, seldom necessary, and, indeed, the cartilaginous polypi are very rare.

I find, Gentlemen, the time has expired; I will leave the rest of the subject till next week.

[Sir B. C. Brodie directed the forceps and other instruments to be left for the students' inspection. There were several preparations on the table illustrative of the various kinds of polypi.]