We are advised also not to direct it through any region where pus is forming. It should, therefore, be avoided in acute suppuration of the middle ear or of a nasal sinus, prior, at all events, to the opening and draining of the affected cavity.

We conclude a brief and incomplete summary by advising all oto-laryngologists to procure Dr Cumberbatch's book. They will find it easy to read and to comprehend, and as we have been trying to convey, full of suggestiveness. DAN MCKENZIE.

# LETTER TO THE EDITORS.

## THE SURGICAL APPROACH TO THE ETHMOID.

THE EDITORS,

*The Journal of Laryngology and Otology.*

DEAR SIRS,—Mr C. A. Verge in his interesting contribution on the above subject in the April number of the *Journal*, shows himself to be so much in agreement with me as to the inadequacy and even danger attending the various methods of intranasal approach that I regret my inability to convince him of the practical advantages of the transantral method I have advocated. I regret it all the more because such a line of approach could most reasonably be adopted in the twenty-six "very chronic" cases he has operated upon in which there was presumably concomitant disease of the antrum.

As I have frequently had occasion to carry out the Howarth type of operation on the frontal and ethmoidal sinuses (from which Mr Verge's ethmoidal operation differs only in detail), I can claim to have a reasonable knowledge of both methods of approach and, whilst I agree with Mr Verge that his method offers the best and perhaps the safest facility to eye and hand, I am of opinion that in the presence of ethmoiditis alone (a contingency which I agree with him must be of rare occurrence) his operation is too protracted and too drastic in its performance. In those cases of concomitant disease of the maxillary antrum it is possible, working across the antrum, to take down the anterior wall of the sphenoidal cavity and clear out the whole ethmoidal capsule with a Moure's curette within a couple of minutes.

Mr Verge states that in his experience ethmoidal suppuration is very much more frequent than frontal sinus infection, and "almost as frequent as maxillary sinus infection." Whilst I agree with him that "every case of ethmoiditis does not require a radical antrum operation," I contend, and practical experience has taught me, that every case requiring a radical antrum operation is a highly potential case of ethmoiditis, and that at the conclusion of a radical antrum operation the trained hand can readily verify the doubt; should ethmoiditis exist, its removal can be rapidly and thoroughly carried out.

Mr Verge states that his main objection to this type of operation is that "when a surgeon is working in the posterior ethmoid region he cannot see the highest or widest limits to which he may go . . . and especially is this the case when he is working upwards and backwards towards the dangerous area." My reply is that the dangerous area is not the post-ethmoid-sphenoid regions where the boundaries are constituted by relatively thick bony laminæ, *i.e.* the vertical plate of the palate bone with its orbital and sphenoidal processes, the body and the lesser wing of the sphenoid and the medial part of the orbital surface of the frontal bone; the dangerous area is the bony boundaries of the olfactory cleft and more particularly the cribiform plate and the medial surface of the middle turbinal. I have laid great stress on the necessity of avoiding *this* dangerous area and on the advisability of, as far as possible, preserving the middle turbinal. In cases where it is manifestly diseased, I defer its removal to the final stages of the transantral operation on the ethmoidal cells.

I have not been conscious of any difficulty in clearing out "border cells" whilst working across the antrum with Moure's curette and I do not think the view obtained of the post-ethmoid-sphenoid region from the external wound is as satisfactory as that usually obtained across the postero-internal angle of the antrum.

In cases where either the clinical symptoms or the X-rays suggest the concomitant existence of frontal sinus disease, I would certainly give preference to the type of operative approach advocated by Mr Verge, but as far as my personal experience goes, I have been unable to obtain practical confirmation of the frequency of frontal sinus infection which he assumes to occur in cases of long-standing suppurative ethmoiditis with polypus formation.—Yours, etc.,

J. B. HORGAN.

CORK, *April*, 1928.

# GENERAL NOTES

ROYAL SOCIETY OF MEDICINE,

1 *Wimpole Street, London, W.* 1.

*Section of Laryngology.—President*, Mr Harold S. Barwell, F.R.C.S.; *Hon. Secretaries*, Mr W. M. Mollison, M.Ch., 23 Devonshire Place, London, W. 1, and Mr Lionel Colledge, F.R.C.S., 2 Upper Wimpole Street, London, W. 1.

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The Sections of Laryngology and Otology will hold their Summer Meeting conjointly on Thursday, 31st May, and on the two following days, 1st and 2nd June.