SELECTED ABSTRACTS FROM NATIONAL MEDICAL JOURNALS

Pages with reference to book, From 252 To 253

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MANAGEMENT OF RESPIRATORY STRIDOR. Yousuf N., Khan, M. Pak. J. Otolaryngol., 1986; 2: 12-13.

A retrospective study of 72 children with acute respiratory stridor, between 1981 and 1984, is presented. As this is a medical emergency caused by either an inflammatory process or foreign body in the upper airway, a tracheostomy is usually needed. All the 72 cases studied were kept under observation, antibiotics, antihistamines, sedatives and humidification. Nutrition was maintained and where necessary antidiphtheric serum was injected. 40 patients improved oh these measures and 16 cases required tracheostomies, of which 2 died due to carditis. Of the 16 subjects with a definite or doubtful history of foreign body, 2 underwent bronchoscopy for removal of the foreign object and 14 had extraction of the foreign body through the tracheostomy. In the infective group of patients the tracheostomy was delayed as much as possible due to the decannulation problem. Children with foreign bodies were subjected to tracheostomy under boat anaesthesia over the third or fourth bronchial ring. Resection of the cartilage ring was avoided. As bronchoscopy requires general anaesthesia, which may not be available in emergency, tracheostomy provides an easy and alternate route for removal of foreign bodies from tracheobronchial tree.

RHINOPLASTY. Marfani, S., Beg, M.H.A. Pak. J. Otolaiyngol., 1986;2:43-46.

Amputation of the nose is known since ancient times. The main reasons usually were punishment after losing a war and adultery. Reconstruction of the cut nose has also been done by ancient Indians by raising a flap from the cheek. The case of a 45 year old man who married a girl against the wishes of her family is presented. His nose was amputated with a sword while he was sleeping. On examination the entire soft parts of the external nose were absent including the septal cartilage and lateral nasal cartilages. Surgery was performed under general anaesthesia. A full thickness skin graft was taken from the forehead with pedicle based on the anterior branch of the right superficial temporal artery. The distal end of the graft was turned inward to provide the inner lining of the future nose, and then sutured to the stump joining the alar and columellar fold. This was kept in place bya BIPP packing. The rest of the graft was sutured to form a tube. The forehead was covered with a split thickness graft taken from the thigh. Six weeks later the tube pedicle graft was divided at the nasal end. The nasal tip was reconstructed along with the alar folds. The pedicle was divided at its base. The patient made a satisfactory recovery. Various workers have used skin flaps from different parts of the body for reconstruction of the nose. The forehead provides a well matched skin and texture for the purpose. A full forehead flap cosmetically gives uniformity to the whole forehead and an indistinct scar. The anterior branch of the superficial temporal artery should be kept intact to maintain the flap. Reconstruction surgery done in the stages over a period of three months gives more satisfactory results.

PSEUDOGLOTHS A VOICE RESTORATIVE PROCEDURE FOLLOWING TOTAL LARYNGECrOMY. Zaidi, S. H. PalcJ. Otolaryngol., 1985;1:13-66.

17 cases who underwent total laryngectomy were further subjected to pseudogbottis formation by Staffiaris' technique for speech restoration. There were 15 males and 2 females with ages ranging between 29 and 69 years. Most of the cases presented in the advanced stage of the disease and pseudoglottis formation was carried out at the time of laryngectomy. A permanent tracheostomy was designed at the fifth tracheal ring and a cuffed portex tracheostomy tube inserted. The trachea was divided followed by laryngectomy. Four stay sutures were applied at the site of the pseudogbottis, in the oesophageal muscularis and a buttonhole created. Pharyngeal mucosa was then sutured to the

oesophageal muscularis using Prolenç. The posterior wall of the trachea was secured to the anterior wall of the oesophagus. A 7mm soft polyvinyl tube was inserted through the buttonhole and withdrawn through the nose and retained as such for 3 weeks. The tracheal hood and pharynx were repaired. Speech was tested towards the beginning of the third week. 12 patients had excellent speech, whereas 3 had a good recovery of speech. There were 2 failures with one having complete stenosis of the shunt. There was no mortality. Hospitaliza tion varied from 12 to 21 days. Staffiaris' technique of pseudoglottis formation is simple, being performed at the lime of primary surgery and gives excellent results.

RADIOTHERAPEUTIC MANAGEMENT OF CARCINOMA NASOPRARYNX. Khan, MS. Pat J. Otolaryngol., 1985; 1:99-101.

19 cases of carcinoma nasopharynx managed by radiotherapy are presented. Most of the patients reported in an advanced stage with 9 having unilateral and S bilateral cervical lymph node involvement. Large treatment fields were applied includbig the entire neck, nasopharynx and base of the skull. A tumour dose of 50 grays was delivered using cobalt 60 tele-therapy. Patients with nasal extension received an extra dose of 15-20 grays through the anterior nares. 60 percent of the cases showed a good clinical response with tumour regression. Older male patients with well differentiated squamous cell carcinoma had a poor response. Recurrence within a year was noted in patients with bilateral neck nodes. They were given combination chemotherapy with eyelophosphamide, Bleomycin and Cisplatinum. Most of the tumours of the nasopharynx arise from the Rosenmuller's fossa. Almost 80 percent of the patients present with cervical metastasis. Surgery does not have a role in these tumours. The treatment of choice is radical radiotherapy to the primary tumour and its extensions.