

Letter to the Editors

of the larynx, and the ulcerations underwent a notable improvement. In only one case was the improvement maintained up to the time of reporting (nine months later). The other two cases died nine and six months respectively after the operation of acute extension of the tuberculous process in the lungs.

G. WILKINSON.

Sympathectomy for Ozæna. GEORGES PORTMANN. (*Revue de Laryngologie*, October 1926.)

The operation was proposed by Berten, and has been carried out by Beyer and Asteriades, and also by d'Halphen and Mile Schulemann. These operations were done on the external carotid only.

Portmann expected better results from operation on the common carotid. Ozæna attacks the nasopharynx, pharynx and larynx, as well as the nose, and by operating on the main trunk the destruction of the sympathetic branches going to the superior laryngeal, and ascending pharyngeal which arise from the external carotid close to its origin could be assured. Four cases in all were operated on. The artery was denuded for 3 cm. of its length immediately below its bifurcation.

For the first few days after the operation the mucous membranes were swollen and congested, and the secretion was increased. Crusts were discharged and the odour disappeared in twenty-four to forty-eight hours. The cases had been under observation two to six months at the time of reporting. All had improved, but a certain amount of crusting was present in all, and the atrophic condition persisted, though it seemed to be less marked.

G. WILKINSON.

LETTER TO THE EDITORS

NERVOUS AFFECTIONS OF THE ŒSOPHAGUS.

THE EDITORS,

The Journal of Laryngology and Otology.

SIRS,—I have read Dr Brown Kelly's excellent article on "Nervous Affections of the Œsophagus" in the *Journal* of April and would like to ask at this late date, a few questions.

He quotes Dr Abel thus: "The uniformity of the coats (of the œsophagus) and the absence of a sphincter are clearly demonstrated. Stimulation of the peripheral ends of the cut vagi causes contraction over the whole œsophagus, but dilatation of the cardiac canal, as takes place in normal deglutition; whereas, section of the vagi without stimulation is followed by dilatation of the œsophagus, without relaxation of the cardia."

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Did this contraction take place simultaneously or in a peristaltic wave, when the lower end would open, as one knows happens in normal peristalsis?

Dr Brown Kelly shows that the œsophagus is supplied throughout by the tenth nerves and the great splanchnic nerves.

Now, if the dilatation be due to paralysis of the nerves, owing to degeneration in Auerbach's plexus, why do the abdominal œsophagus and stomach remain unaffected?

Chevalier Jackson, on the other hand, says that there is no sphincter in the abdominal œsophagus; that the sphincter is in the diaphragmatic opening, where, associated with the crura, there are special muscle fibres developed in the œsophagus. This muscle development would be supplied by the phrenic nerve and that would account for spasm in this area. If Jackson be right, then spasm precedes dilatation. Jackson's contention, then, that stretching of the sphincter cures the condition, is reasonable.

I have recently had two cases, one with enormous dilatation of the œsophagus and the other with moderate dilatation, and both experienced great difficulty in swallowing fluids; one stretching with a large Jackson tube apparently cured the condition. Both patients are now taking ordinary meals, the former with some symptoms of having to push the food down, the latter with no difficulty at all.

On one occasion when a stomach was opened, with the consent of the surgeon, I passed a gloved finger into the abdominal œsophagus without any sensation of grip, but could not get my finger through the diaphragmatic opening without force. The patient was allowed to come out of the anæsthetic a little and I found the diaphragmatic opening closed against my finger.

There is another possible explanation of the condition: the lower part of the œsophagus is supplied, additionally, with fibres from the lower dorsal nerves. It may be due to these that spasm occurs. This would fit in with both theories, namely, the pre-dilatation and the post-dilatation theories.

D. J. Cunningham states that in a full stomach the abdominal œsophagus disappears, becoming part of the stomach! If the sphincter be there, then, how does this occur and why is the food not regurgitated? Again, the obliquity of attachment to the stomach and the unequal lengths of the four aspects of the œsophagus make it difficult to believe that there is a sphincter in the so-called cardia.

I write this in no hypercritical spirit, but would like Dr Kelly to give me some enlightenment on this exceedingly interesting subject. At the same time, I wish to thank him for his very able treatise.—
Yours faithfully,

T. A. MACGIBBON.

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