

SELECTED ABSTRACTS

Pages with reference to book, From 273 To 274

Ankylosis of the Temporomandibular Joint- Part 3. N.L. Rowe. f.R.Cóll. Suig., Edinb., 1982, 27: 209-218.

A STEP-BY-STEP, detailed description of how to repair ankylosis of the temporomandibular joint is presented. It is stated that intubation should be carried out with a fiberoptic endoscope under direct vision. A tracheotomy kit should always be at hand, and the surgeon should be prepared to perform an emergency operation if it is indicated. The technique of how to achieve the exposure is described in detail. The author believes that the subcondylar osteotomy and removal of the bony mass are indicated and that the width of the osteotomy should be at least 2 cm. if recurrence is to be avoided. The risk of relapse is also reduced if an interpositional arthroplasty with the temporalis muscle is used.

Gordon G.Thomas

Control of Astigmatism After Surgery and Trauma. M. J. Roper-Hail. Br. J. Ophthalmol., 1982, 66: 556-559.

THE INTRODUCTION of microsurgical procedures with very fine nonabsorbable sutures has resulted in the more accurate closure of wounds of the cornea but has also resulted in occasional high degrees of astigmatism because one or more nylon sutures were closed with greater tension than others. In most instances, a positive cylinder is induced in the axis of the tight suture. If interrupted sutures are used, then the author suggests that the tight suture should be removed. It is wise to wait about six weeks for the wound to be solidly healed before attempting such removal. The astigmatism will decrease almost immediately and almost always within a few hours. if a continuous running suture is used for closure of the wound instead of interrupted sutures, then the point of tightness must be relieved. This can be done by stretching the nylon suture toward the area of greatest stress. Nylon has a certain amount of give, and pulling gently on the suture with smooth forceps results in some slack being introduced into the closure. Two patients are presented to illustrate the effectiveness of these two procedures.

David Shoch

Complications of Mastoiditis with Special Emphasis on Venous Sinus Thrombosis. Frank R. Venezia, Thomas P. Naidich and Stanford T. Shulman. J Pediatr., 1982, 101: 509-513.

THE DIAGNOSIS of postotitic mastoiditis is often difficult, and the intracranial complications have become rare since the advent of antibiotic treatment. Two children with intracranial venous sinus thrombosis complicating mastoiditis prompted a review of the experience at Children's Memorial Hospital in Chicago that disclosed that 15 patients had mastoiditis during a ten year period. Venous sinus thrombosis was encountered in four children, and intracerebral abscess was encountered in four children, and intracerebral abscess was seen in one child.

The authors emphasize the low yield of traditional roentgenographic studies to confirm a clinical diagnosis. Contrast media-enhanced computerized tomography proved to be a valuable adjunct in the diagnosis of serious complications of mastoiditis. An arteriographic procedure is still recommended to confirm venous patency or occlusion prior to operation because of developmental variations in venous drainage patterns. The need for optimal surgical therapy in addition to administration of antibiotics is again emphasized.

Helmuth Goepfert

Pain and Dysphagia in Patients with Squamous Carcinomas of the Head and Neck; the role of Pen-neural Spread. R.L. Carter, MR. Pittam and N.S.B.Tanner. J.R. Soc. Med., 1982, 75: 598-606.

THE AUTHORS reviewed the pathologic findings of 100 patients who were treated with surgical procedures for squamous cell carcinoma of the buccal cavity, oropharynx, hypopharynx, nose and paranasal sinuses. In addition, they reviewed the pathologic findings of 17 patients submitted to autopsy who had died as a direct result of squamous cell carcinoma of the head and neck area. Clinical and pathologic findings of perineural spread were present in 76 per cent of the patients who were operated upon. The over-all rate of nerve involvement detected morphologically was 44 per cent. This rate was slightly higher among patients with lesions of the buccal cavity, 51 per cent, than among those with tumors resected from the oropharynx, hypopharynx and cervical esophagus, 34 per cent. Neurologic findings were dominated by hypesthesias, parasthesias and referred pain, mainly in the territories of the fifth and ninth cranial nerves. Occasionally, multiple and sequential nerve involvement was found. There was no correlation between the incidence of nerve invasion and the incidence of metastasis to regional lymph nodes. Massive infiltration of nerve trunks and extension of this spread along larger nerves were associated with poor prognosis. Sixty-five per cent of the patients studied at autopsy showed a correlation between their clinical presentation and pathologic evidence of perineural spread. The over-all rate of nerve involvement detected morphologically was 88 per cent; multiple nerve involvement was observed in 33 per cent of these instances. The authors further described a dysphasia syndrome which, in their opinion, was caused by a combination of perineural spread of tumor into the ipsilateral vagal trunks, sometimes accompanied by variable invasion of the sympathetic chain, and a splinting effect on the pharynx, caused by local fibrosis and tumor of soft tissues of the neck.

Helmuth Goepfer