

Y. J. Hay

Staff Meeting Bulletin
Hospitals of the » » »
University of Minnesota

Paranasal Sinusitis

STAFF MEETING BULLETIN
HOSPITALS OF THE . . .
UNIVERSITY OF MINNESOTA

Volume X

Friday, October 21, 1938

Number 4

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Published for the General Staff Meeting each week
during the school year, October to May, inclusive.

Financed by the Citizens Aid Society

William A. O'Brien, M.D.

I. LAST WEEK

Date: October 14, 1938

Place: Recreation Room
Powell Hall

Time: 12:20 - 1:20

Program:
Movie: "Fox Hunt"

Announcements

Gas Anesthesia
Ralph T. Knight

Discussion
Sydney C. Wigger,
Boston, Mass.
Harry J. Shields,
Toronto, Ont.
Phillip D. Woodbridge,
Boston, Mass.
Ralph T. Knight

Present: 180

Correction: Staff List "Fellows"
should be "Interns"

Gertrude Gunn,
Record Librarian

II. MOVIE

Title: "Light Waves and Their Uses"

Released by: Erpi Corporation.

III. ANNOUNCEMENTS1. FELLOWSHIP APPOINTMENT

Albert F. Hayes, St. Paul
Minn., B.S. '36, M.B. '36, M.D. '37 -
University of Minnesota. Rotating In-
tern, University of Minnesota Hospitals
1936-38. Fellow in Obstetrics and
Gynecology 1938---.

2. RICHARD OLDING BEARD LECTURE

Ballroom, Nicollet Hotel,
Friday, October 21, 8:15 p.m., by
Major Julia C. Stimson, President,
American Nurses' Association.

Title: What Everyone Wants
but Does Little About.

All nurses and their friends
invited to attend lecture and reception
to follow.

3. MINNESOTA RADIOLOGICAL SOCIETY

Fall meeting, Saturday,
October 22, at 2:00 p.m., Room 1536
Mayo Clinic, Rochester, Minnesota.

Informal dinner, 6:30 p.m.,
University Club, Rochester.

4. INTER-DEPARTMENTAL SEMINAR

Wednesday, October 26,
1938, 8 p.m., Eustis Amphitheater.

Speakers: R. G. Green
E. A. Boyden
W. T. Peyton

IV. PARANASAL SINUSITIS

F. L. Bryant

1. The management of an individual with sinusitis may consist of the correction of a single obvious factor or it may require well planned medical or technical surgical procedures. Sinusitis may occur as an acute, subacute, or chronic condition. Before any plan of management, medical or surgical, is decided upon, a thorough examination of the individual and an evaluation of his problem is imperative.

2. During the past two or three decades important contributions to the knowledge of anatomy, physiology, allergy, and surgery have done much to clarify the problem of sinusitis. Recent advances in the field of immunology and chemotherapy have materially aided in the care of the patient with acute sinusitis.

a. Anatomy: the nose and the paranasal sinuses cannot be practically dissociated. The middle turbinate which is part of the ethmoid labyrinth, occupies a crucial position in the nasal cavity. Below the middle turbinate are the openings of the frontal, maxillary, and anterior ethmoid sinus groups; above are the openings of the posterior ethmoid group, and posteriorly is the sphenoidal sinus ostium. The nasal septum, which divides the nose into its two sides, may be thickened, irregular or deflected. Such irregularities, by pressing on the middle turbinate may interfere with the ventilation and drainage of the sinuses on the obstructed side. In the upper jaw the molar and premolar teeth which have roots extending into the maxillary sinus may be the cause of infection in that sinus.

b. Certain aspects of nasal physiology are worthy of brief review to afford a clearer conception of the problem. The

primary functions of the nose concern its ability in supplying moisture to the inspired air and in the heating of it. The nose also serves as a filter for bacteria, pollen and dust. It has been estimated that 2 quarts of water are given off by the nose in a 24 hour period. The nose is lined with a ciliated columnar epithelium. The direction of the ciliary activity is downward and backward; the gradient of increasing activity increases in these directions and also is very active around the sinus ostia. The cilia are covered by a protective layer of mucus. Twenty-eight degrees centigrade to 33° C. has been found as the optimum temperature for ciliary activity. Drying increases the viscosity of this layer of mucus which results in a lessening of the ciliary activity. Chilling likewise diminishes their sweeping and cleansing functions. Certain drugs, such as zinc, cocain and adrenalin have deleterious action on the movement of the cilia.

c. Allergy of the nose and paranasal sinuses is a complex clinical entity. The manifestations are both varied and variable. Allergy may manifest itself primarily in the nose or equally in the nose and paranasal sinuses. Unless the symptoms are severe or the individual is unusually solicitous about his nasal functions, he will not likely be seen in the earliest stages. The presence of allergy in the nose may invite infections, and by the existence of allergy the infection which does occur may be, and often is, unduly prolonged.

d. Surgery: amputation or partial removal of the inferior

turbinate was formerly practiced. This procedure is seldom if ever resorted to by rhinologists. It has been shown, however, that removal of the middle turbinate can be done without untoward effect on the nasal physiology. Endonasal procedures were formerly used almost exclusively for attacking all grades and locations of chronic sinus infection. The mutilating and deforming Killian operation which did much to cause condemnation of sinus surgery was done as a measure of last resort and with questionable results. Today it is seldom necessary to do this procedure except in isolated instances. The combined external and internal approach of the ethmoids and associated sinuses with ligation of the ethmoidal and sphenopalatine arteries permit the operative field to be under direct view of the surgeon's eye. The incision is essentially the same as for a dacryocystectomy. Tedious after-care and long hospitalization are eliminated. These are distinct economic factors.

- e. Immunology and chemotherapy have greatly aided in the care of patients with severe acute sinusitis. Transfusions of whole blood, and sulfanilamide for the streptococcal infections have and will materially decrease the mortality and morbidity of this type of sinusitis.

3. Etiology: Sinusitis, irrespective of any other associated condition such as tumors, syphilis, tuberculosis, practically always has its inception by bacterial invasions. Trauma, injudicious therapy (medical or surgical) during an acute rhinitis, and the acute exanthemata of childhood are the essential predisposing causes in acute sinusitis. Chronic sinusitis develops when there is faulty aeration and drainage from the sinuses and the natural protective mechanism of the body both local and general is interfered with. Dietary (vitamin) deficiencies,

endocrine imbalances are likewise important.

4. Classification of sinus disease

- A. Acute "the more acute the process, the more typical are the symptoms, and the simpler the diagnosis" Lederer.

1. Fulminating

- a. History of head cold, followed by swimming, trauma, or injudicious therapy.
- b. Examination reveals an intensely sick individual with or without pain, swelling, associated with the involved sinus. High fever, toxicity, and intracranial complications present or eminent. Red nasal mucous membranes with sero-purulent exudate.
- c. X-ray shows involvement of suspected sinuses.

2. Surgical

- a. History of head cold, swimming, or acute exanthemata.
- b. Examination reveals an intensely sick individual but with complications not present. Resistance not adequate to cope with infection unless drainage of products of infection removed. Intranasal examination reveals swollen turbinates and purulent exudate filling nasal cavity.
- c. X-ray involvement of suspected sinuses.

3. Medical

- a. History of head cold which preceded sinusitis involvement. Pain and fever present; usually little or no external swelling. Intranasal examination reveals swollen turbinates and purulent exudate in meatus
- b. associated with the involved sinuses.
- c. X-ray shows involvement of sinuses.

B. Subacute

The findings in this stage are essentially the same as in the acute but to a much less degree. Undoubtedly many individuals have subacute sinusitis and spontaneously recover without consulting a physician.

C. Chronic

1. First degree:

- a. History of frequency of head colds and few if any symptoms in interval between colds.
- b. Examination reveals few if any intranasal findings. May have a deviated septum, a localized enlargement of middle turbinate, etc.
- c. X-ray shows usually negative findings or, if positive, confined to one and not over two sinuses.

2. Second degree

- a. History of continuous but slight symptoms.
- b. Examination showing slight to moderate intranasal findings.

- c. X-ray shows involvement (definite but not marked) in at least one sinus; often present in two.

3. Third degree

- a. History of continuous and definite symptoms.
- b. Examination reveals moderate to marked involvement of turbinate structures.
- c. X-ray shows moderate to marked involvement of two or more sinuses.
- d. Those in whom previous management has given no relief or temporary relief.

4. Fourth degree

- a. History of continuous and marked symptoms.
- b. Examination reveals marked intranasal findings (enlarged turbinates filling the nasal cavity and often covered with mucopus and crusts).
- c. X-ray involvement of all sinuses on one or both sides.
- d. Those in whom previous management has had no effect.

5. Symptomatology of Patients Operated for Sinusitis

In the eight patients who required surgical interference only four of them complained of pain and headache. All complained of severe nasal obstruction and seven had purulent nasal or post-nasal discharge. Inflammatory swelling over the involved sinus was present in five.

All of the patients in the allergic group of seventeen had nasal or post-nasal discharge; it was either mucoid or mucopurulent and essentially continuous. Sixteen of the patients had nasal obstruction. It varied from partial to complete. Only four of this group complained of headache and this was given only as a major complaint in but one.

In the group with chronic, non-allergic, sinusitis of which all varieties are represented headache was given as a chief complaint in twenty-four of the forty-six patients. Nasal obstruction varying in degree from moderate to absolute was present in thirty-five. Nasal and post-nasal discharge, occasionally mucoid but more often mucopurulent or purulent was present in thirty-nine individuals. The nasal discharge and nasal obstruction were uninfluenced by local treatment, self medication or minor operative procedures. On the other hand headache was found to be variable in its occurrence and could be considered present continuously in but twelve of the twenty-four patients.

In the complete group of 71 patients but 32, or approximately 45% gave the symptom, headache, as a complaint. The more indicative symptoms were found to be nasal or post-nasal discharge, usually purulent in character and nasal obstruction varying from moderate to complete. This conception may be at a variance with that commonly held by the non-rhinologist. The presence or absence of headache can be considered to be of minor importance from a diagnostic point of view.

6. Resume'

During the four year period, 1934 to 1937 inclusive, from which a study of sinusitis was made, there was a notable absence of patients with acute sinusitis which required surgical interference. No patient who presented himself to us at the inception of the acute attack required surgery. The University of Minnesota Hospital is not a general city receiving hospital, yet during this period as near as can be estimated, not less than two hundred patients with some form of acute sinusitis were seen in the dispensary and in the Student Health Service.

Manipulative procedures such as infracturing middle turbinates and the surgical removal of bullar cells or anterior ends of middle turbinates, ephedrine-saline displacements, sodium chloride irrigations, were not employed as a general rule. Only when the peak of acute infection had been safely passed were a few of the more conservative measures resorted to. Rest, partial to absolute, depending upon the severity and progress of the infection, silver-protein drops, steam inhalations, and hot compresses and nasal suction constituted the main forms of management. Throughout the entire period of acute sinusitis, the patient was cautioned against blowing the nose.

The histories of patients who were operated for sinus infection were analyzed to determine what factors were present which necessitated this type of management, and likewise, what factors were important in the actual management.

Factors in acute sinusitis

There were eight patients admitted to the hospital with a diagnosis of acute sinusitis which was felt had become surgical. Of these, three died and five lived. Their histories are of interest.

1. R. P., male, aged 19, was admitted with a temperature of 103° F., pulse 160, respirations 22. He complained of pain, redness, and swelling over left forehead. Examination revealed a swelling involving left frontal and parietal area; cellulitis of the left periorbital tissues. Purulent exudate filled the left nasal cavity. Further questioning revealed the edema had been present for 24 to 36 hours. The symptoms of acute sinusitis had developed following swimming several days previously. Operation consisted of incision and drainage in naso-frontal area. Death occurred within 12 hours from admission. Autopsy report: Acute cerebral edema, thrombosis of jugular bulb, bilateral purulent sinusitis, edema of scalp.

2. E. M., male, aged 22, who gave

a history of swimming when he very likely had a head cold. Eleven days before admission the patient developed pain in chest and a cough with bloody expectoration. On admission there was edema of left forehead and the left eye was closed. The history also revealed irrigations and intra-nasal treatments. Operation consisted of simple incision and opening into frontal sinus at naso-frontal region. The opening revealed pus under pressure, osteomyelitis of posterior plate of frontal sinus and dura covered with infected granulation tissue. A brain abscess existed. This was opened and drained on four separate occasions. The patient ultimately died from multiple brain abscesses.

3. G. A., female, aged 40, gave a history that six years ago she had had multiple dental extractions in the upper jaw. From that time she dated her nose and head trouble. A few days before admission she had a severe head cold and expectorated bloody sputum. When first seen, she was extremely ill and had complete blindness of her left eye. Examination showed a complete occlusion of the left nasal cavity with swollen turbinates and mucopus. A conservative external ethmo-sphenoidectomy was used because of the intense inflammatory reaction in the turbinates. It was done earlier than normal for two reasons: first, so that adequate drainage could be established as the patient was rapidly losing ground; and second, as an attempt to save the vision. However the patient became progressively worse and died three weeks later. Autopsy showed multiple emboli and an old infarct of the lung.

In the five patients who lived, surgical treatment consisted of conservative drainage procedures in four. One of these had several small blood transfusions. A fifth patient had intra-nasal treatment which was directed to an old sphenoid infection. When the disease had reached a subacute stage, opening and drainage by an external ethmo-sphenoidectomy was done with prompt recovery.

The important factors in the management of acute and subacute sinusitis are namely, (1) to avoid any procedure which

may accentuate the infective process or impair the work of the protective agencies of the body; (2) to supply the body with immune bodies; (3) to remove the products of the infection only when overaccumulated. In each of the three patients who died there existed at the time of admission, more than acute sinusitis. The infection was so virulent and the individual's immunity so low that no resistance was offered to the process. Supportive measures, especially small blood transfusions as pointed out by Gill would have been worthy of use earlier in the disease. The blood is given not so much for the red blood cell value, but for the immune bodies which are introduced. Chemo-therapy, likewise, has a definite place in the management. Metaphen may be of value in staphylococcic infections; sulfanilamide has been generally accepted for streptococcic infections.

In those individuals who are seen with early acute sinusitis, optimum temperature and humidity relations are important for this permits the nasal mechanism to relax normally. By so doing the major portion of energy can be utilized in healing the infected tissues and not in warming and moistening the inspired air.

Chronic sinusitis

Factor of allergy in chronic sinusitis: There were seventeen patients who had associated with chronic sinus disease allergy of such nature and extent that in our opinion sinus surgery was indicated. The histories of all indicated they had allergy coexisting and undoubtedly preceding the sinusitis.

Of the seventeen, five also had bronchitis or bronchiectasis. Thorough exenteration of the disease process in the sinuses and treatment of the chest problem by iodized oil instillations together with allergic management, brought about improvement. Two of these who had asthma obtained variable relief. Two of the seventeen manifested no general symptoms of allergy. Thorough exenteration of all diseased tissue gave complete cures as evidenced by several

follow-up examinations.

Five patients had bronchial asthma associated with sinusitis. Four were improved and one was not. All had allergic management.

Three patients who had sinusitis apparently on a basis of food allergy were operated. The results were good in the one who adhered to his dietary restrictions. Two did not respond for follow-up examinations and treatment.

Of the remaining two, one had obesity and hypothyroidism. Sinus surgery, diet, and thyroid therapy improved her materially. One, a sixty-nine year old woman, was miserable with complete nasal obstruction and postnasal discharge. Bilateral Caldwell-Luc Operations and conservative intra-nasal ethmoid exenteration gave improvement.

Patients with advanced sinusitis and allergy require dual management. When a patient has sinusitis which is of both infective and allergic origin, that is, when it has reached the irreversible stage and a chronic infective pansinusitis of a third or fourth degree is present, thorough sinus surgery is indicated. Afterward allergic management must be continued if the patient is to forestall a repetition of the trouble.

In patients in whom allergy can be ruled out, one must still keep the patient in mind. The individual will feel as well as the weakest part or organ of his body. If a diagnosis of sinus disease is made and to it is attributed the cause of another disease process, one must be guarded as to the amount of help which will be obtained if the sinuses are operated upon. If a too liberal prognosis is made and the other process is not or cannot be managed, sinus surgery will be deemed a failure by the patient, his family, and often his family doctor. The rhinologist may still hold or maintain that infection has been eliminated from the nose and sinuses.

In those patients with a third or fourth degree chronic sinusitis whose complaints are entirely referable to the

nose and sinuses and no other disease exists a good prognosis may be given. This is true only if the surgical-anatomical problem is recognized and adequately managed.

There were forty-six who had chronic sinusitis on an infective but non-allergic basis, and who illustrate obvious phases of this problem.

Five of the forty-six had chest involvement ranging from bronchitis to bronchiectasis. All had complete surgery on the involved sinuses. Two did not return for follow-up examinations; the three who were also treated with iodized oil instillations into the bronchi showed definite improvement. Each had a gain in weight diminished cough and a lessened amount of expectoration.

In other words, if the patient has developed a definite chronic pansinusitis, or a localized chronic sinusitis of the fronto-ethmoidal or ethmo-sphenoidal or maxillary areas, adequate, clean, and thorough surgery is indicated. This should not convey the meaning of radical. Because of the intricate anatomy of the ethmoid labyrinth and its intimate association with the other sinus openings, it is held by many it is not anatomically possible to do a complete endo-nasal procedure. Periorbital ethmoid cells, sphenoidal alveoles and recesses, and the coincident operative bleeding obviate completeness. Glatt of Chicago has shown that residual islands of mucous membrane may sometimes become seats of infection which spread and subsequently give rise to a surgical failure. Repeated endonasal procedures have not been uncommon, due to the anatomical inaccessibility of the distal ethmoidal cells. The residual infected tissue is notorious in acting as a focal point in continuing the infection.

There were twelve of the forty-six in whom no other disease process was associated. The problem of the surgical anatomy of the sinuses was the major one.

- 1 patient with supraorbital fistula and unilateral pansinusitis.
- 3 patients with bilateral pansinusitis.
- 2 patients with maxillary sinusitis with dental fistula.
- 5 patients with unilateral pansinusitis.
- 1 patient with maxillary pansinusitis.

In this group of patients the chief ~~complaints~~ were entirely referable to the nose, with the exception of those due to drainage from the frontal or dental fistulae. The complaints dated from six months to a year, in the patients with a dental fistula. The others gave histories of nasal symptoms which were present continuously and becoming progressively worse over a period of from 2 to 10 years. All the patients were managed surgically and the endeavor was made to correct those possibilities which might have initiated the sinusitis. Each one of the twelve patients showed a clinical cure. Those with fistulae showed complete healing. The symptoms of nasal stuffiness to complete obstruction, post-nasal discharge, and headache, rapidly subsided after surgery. Examination of the nasal cavities revealed a smooth moist mucous membrane without crusting.

In the nine patients with pansinusitis, there were periorbital ethmoid cell extensions and in four deep sphenoidal alcoves which yielded to the external fronto-ethmoidal-sphenoidectomy. Intra-nasal surgical management would not have been feasible because of the inaccessibility of the sinus extensions.

Associated diseases: There were five patients in whom the sinus disease antedated a second but not obviously related problem. The subsequent problem became so great that although the nose and sinuses were essentially clean and clear postoperatively, no beneficial general effect could be considered to have been derived from the surgical management. These five patients had, respectively, arthritis and prostatitis, cirrhosis of the liver, neurasthenia (following an earlier removal of testicle), and two were emotionally unstable as diagnosed by the Department of Neuro-psychiatry.

These five patients were still sick, although it was felt they were improved or cured as far as the sinus infection was concerned. A patient's health will be as strong as his weakest organ.

If a patient can have adequate management of both the sinusitis and the other lesion or disease process, he will obviously improve. In a group of seven patients two had diabetes mellitus. Before surgical exenteration of the sinuses was attempted, the diabetes was treated by the Department of Internal Medicine. Convalescence from surgery was uneventful. Three patients had dietary problems. One of the three who was definitely underweight and malnourished had extensive chronic sinusitis. Diet improved the general health to a moderate degree but had much more effect when the sinus infection had been eliminated. The remaining two had respectively, gastroenteritis and cholecystitis. Both were improved with internal medical help but more so after sinus surgery. If sinusitis had been considered as the sole etiology, undoubtedly no appreciable help would have been realized, even though surgical management had been thorough. There was one patient who had a hyperplastic and purulent sinusitis following an attack of scarlet fever, two years earlier. Conservative treatment gave only palliative relief. Bilateral external-fronto-ethmoidectomies were employed and rapid recovery ensued.

Disinclination: There is that group of patients who have definite complaints and present clinical and roentgen ray evidence of sinusitis. A program of management, either medical or surgical, is outlined for them. For some reason they do not elect to continue their treatment which has just begun or only partially been completed. They may present themselves months or years later at the same clinic or some other institution or office for care. Many of them are quick to condemn any help that was offered and will not cooperate. They feel that the sinusitis should be cleared up within a short time. Often another problem is present for which sufficient opportunity of study is not

afforded. Little can be done for this group although this should not deter us from assisting those who will be helped.

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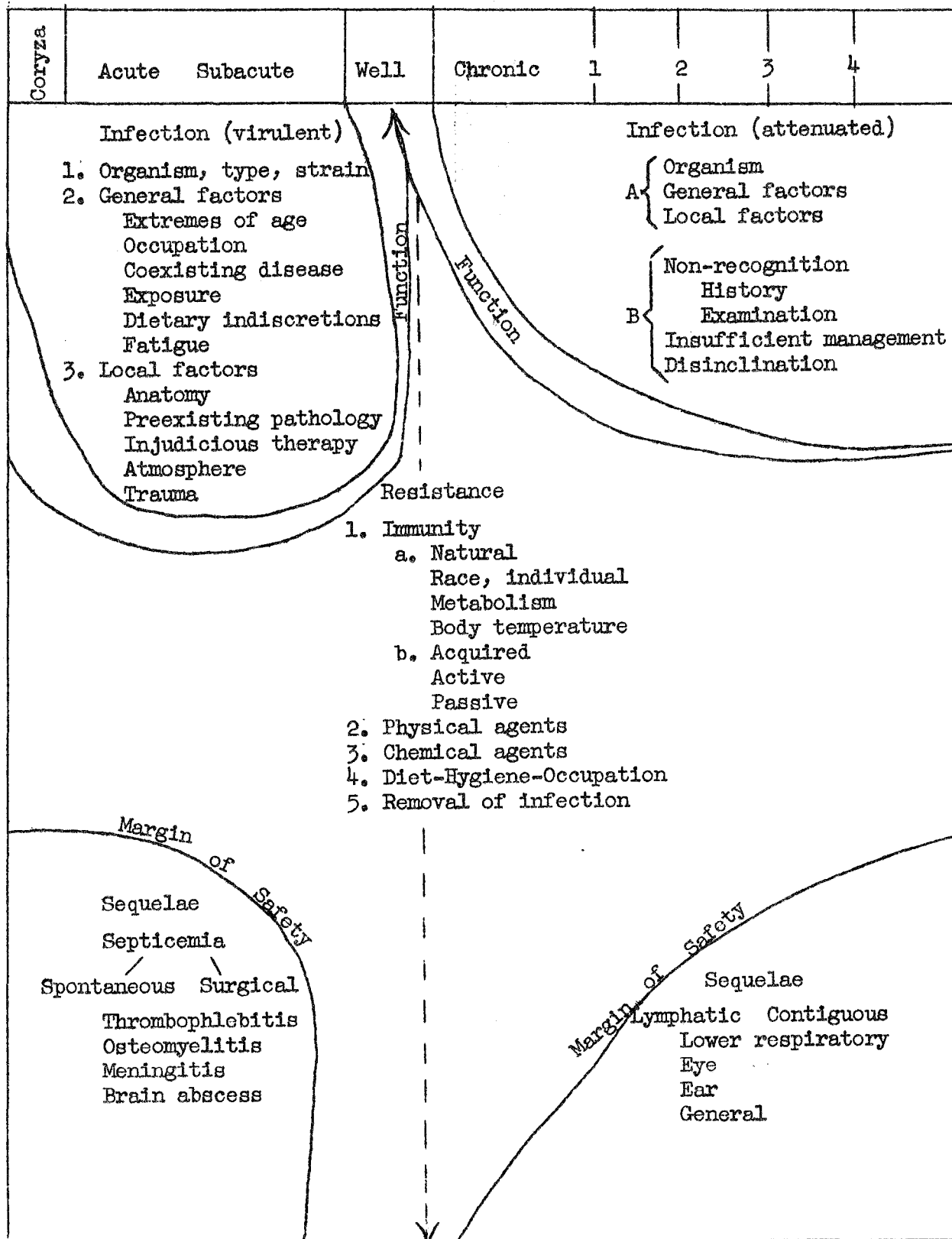
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FACTORS IN SINUSITIS



MANAGEMENT OF SINUS DISEASE

ACUTE DAY(S)	SUBACUTE MONTH(S)	CHRONIC 1° MONTHS	2° TO	3° YEARS	4°
TEMPERATURE AND HUMIDITY					
DIET (VITAMINS) HYGIENE OCCUPATION					
REST IN BED			ANTRUM WINDOWS	CALDWELL LUC Dental Care	DENKER KILLIAN
BIOLOGICAL THERAPY 1. Intranasal 2. Vaccines		3. Artificial Fever 4. Blood Transfusion	Dental Care	EXTERNAL FRONTO-ETHMO-SPHENOIDECTOMY	
CHEMOTHERAPY SPECIAL THERAPY		TONSILLECTOMY AND ADENOIDECTOMY SUBMUCOUS RESECTION CAUTERIZATION OF INFERIOR TURBINATES			
	ASPIRATION AND IRRIGATION FRACTURING MIDDLE TURBINATES			ENDO-NASAL PROCEDURES FRONTAL ETHMOID-SPHENOID	
	EXTERNAL AND (OR) INTERNAL DRAINAGE PROCEDURES		SUCTION TO A PARTICULAR SINUS		
ALLERGY					

The Anesthesia Travel Club through Minnesota's Head Anesthesiologist, Ralph T. Knight, thanks the entire staff for their courteous reception and valuable program of last week. They liked our enthusiasm and cooperative spirit. They were impressed with the Division of Anesthesia, its equipment and personnel. They learned that we really follow the technique of Gas Anesthesia as outlined in the Bulletin, especially in regard to periodically eliminating the excess of carbon dioxide. As leaders in an attempt to better the scientific and professional status of anesthesiology, they felt that their efforts would receive support at the University of Minnesota. We liked them, too, and are glad they came to visit.....

The alumni of the University of Minnesota Medical School also enjoyed their program and visit. The attendance was approximately the same as in other years, and the officers deserve credit for their interest in perpetuating the custom of a scientific and social program at Homecoming time. Following Staff Meeting, there was a spirited business meeting during which plans to better the relationship between the alumni and the School were discussed.

The dinner on October 14 at the Minikahda Club for Dr. J. C. Litzberg was a signal success. The program struck a happy note proving that such affairs do not have to be otherwise. Dr. L. J. Cooke presided with unusual effectiveness. Doc may be retired from active teaching and administration, but he is still everyone's choice for All-American Master of Ceremonies. Wisest wisecrack - "An obstetrician is one who sows tares in his neighbor's field." First honors for most appropriate remarks go to Head Obstetrician and Gynecologist, John L. McKelvey. The Chief, himself, was never in better fettle in thanking the crowd of over 200 for their expressions of appreciation for a job which he hoped was well done. Second program honors belong to Karl Litzberg, the Chief's son, for intimate glimpses of the great in their paternal moments. A scrap book of telegrams and letters of felicitation were visible evidence of the esteem of many who could not be present. All credit for

the occasion's success belongs to Litz's boys who planned the entire affair. Most numerous references were made to the Chief's days as a Drum Major and the many times he lost his pants.....
Jefferson's Professor of Medicine, former Minnesotan Hobart A. Reimann, was a welcome visitor last week. His teaching program at the Center for Continuation Study Wednesday, October 12, of lectures, clinics, demonstrations, and round table discussion, was on the subject of Respiratory Infections in general, and Pneumonia in particular. His new book, The Pneumonias, is receiving wide and favorable notice. He teaches in the same characteristic way and residence in staid Philadelphia has not altered him in any way. He and Mrs. Reimann and their two fine boys spent Thursday visiting with their many friends and making new ones. It was one of those happy events which everyone thoroughly enjoyed.....
 ...Isadore J. Pass, M.D., University of Minnesota, 1932, is now Pathologist at the Macon Hospital in Macon, Georgia. Former graduate student in Medicine, Pathology, Roentgenology, and Anatomy, Dr. Pass is well prepared for success in his new position. His many friends join in sending greetings.....The Annual All Medical Faculty Dinner in the Minnesota Union October 17 drew a goodly crowd of interested faculty members and their wives. New faculty members were introduced and the progress of the Medical School reviewed by Dean Diehl. Among others, reports were heard on the Educational Status of admission to the Medical School and the Department of Postgraduate Medical Education. Dr. McKelvey spoke on China. Everything was peaceful up to this point. Most startling was the youth of many who were introduced with long and imposing records of graduate study, who are now members of our faculty.....The Staff hails the new Chancellor, Guy Stanton Ford, with enthusiasm and pledges its wholehearted support to his administration.....Plans are now being formulated for the Annual Meeting of the Minnesota State Medical Association, May 31 - June 2, 1939, at the Minneapolis Auditorium. Features will include a large Public Health Exhibit for high school students and the public, scientific program and exhibit, and a day devoted to discussion of current medical social problems.....