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Proferred papers. Discussion to papers of Dr Forner, Dr Carter and Dr Gschaedler et al.

Chairman: Dr P. Dollfus

DR JACOBS (*U.S.A.*). I would like to direct a question to Dr Carter. Did he notice that phrenic nerve paralysis is always the same as that seen with direct diaphragmatic problems, namely rupture of the diaphragm? I am wondering if a possible explanation is injury at the site of the diaphragm to the nerve of the diaphragm itself, more so than injury of neck.

Chairman. Dr Carter, would you like to answer that.

DR CARTER (*U.S.A.*). This thing we were not aware about and looked for it simply on a routine film. We have only experienced that in one case in a T10 paraplegic traumatic with severe left-sided pain. This subsided a year and a half later when she came in for plastic surgery, and post-operatively she had vomitting for 3 weeks and we found the entire left chest filled with vomit contents as a result of a traumatic rupture. I've not seen this in any of the others, so it is I suppose a possibility.

DR MINAIRE (*France*). About the last paper, I think the key muscles are not the biceps or the deltoid but the trapezius. We have studied the difference between the trapezius especially the middle and inferior trapezius as compared to the rhomboid. Because the rhomboid is mainly C5 and the trapezius is C4 and when you have a lesion of the trapezius especially unilaterally you must suspect a unilateral involvement of the diaphragm on the same side.

DR GRAHAM SMITH (*U.S.A.*). Did Dr Carter say how many of his patients required tracheostomy in the initial management?

DR CARTER. You are correct; I did not say. My impression is and I don't have this written down but very few of them did. Down in the area of the vital capacity of 1000 to 1100 ccs we will rarely do tracheotomy. Only if they go down to about 800 or 900 so I suspect a very small percentage unless they developed complications and came to us with those.