Bilateral recurrent laryngeal nerve paralysis, clinically known as bilateral abductor paralysis, occurs with relative infrequency. Nevertheless the subject has become particularly important to the laryngologist because the outstanding symptoms of this condition are dyspnoea and inspiratory stridor. This condition is of grave import since it may cause sudden death with asphyxiation. Most of the cases seen by us in a teaching hospital like mine, are due to trauma (thyroidectomy) and a few due to peripheral neuritis.

To correct this, many surgical attempts were made. Nerve repair was advocated by Ballance, Frazier, Lahey and others but the results were unsuccessful due to the dual function of the recurrent laryngeal nerve. In the wake of these, developed the extra-laryngeal and intralaryngeal surgical procedures.

**Intra-laryngeal procedures include:**

1. Hoover (1932) devised submucous excision of one vocal cord through laryngo-fissure.

2. Lawson (1965) of Manchester modified Hoover's operation, excised submucosally the entire substance of the vocal cord and sutures, the two mucosal flaps together.

**Extra-laryngeal procedures:**

King (1939) described an operation which was designed to rotate one of the paralysed cords outwards and thus improving the airway. The arytenoid is mobilised by opening the capsule of the cricoarytenoid joint, by a posterior approach to larynx. A suture is passed through the cartilage and outwards through the posterior part of the ala.

Kelly (1941) reported a modification of King's operation in which the
arytenoid cartilage was approached through a square window in the posterior part of the thyroid ala. The arytenoid cartilage was dissected out and removed and a suture passed through the posterior end of cord.

The other operations include "Clerfs" modification of King's operation, wherein, a window is made in the thyroid muscle is sutured to the thyroarytenoid muscle or the true cord.

Thus one notes a baffling series of surgical procedures in the literature. We have been studying these procedures and seeing a few being done also. We have devised, in our department a method, which we believe is simple and at the same time can be useful to occasional surgeons like some of us.

The procedure is as follows:

A preliminary tracheostomy is done over the third ring of the trachea and then the usual laryngofissure procedure is carried out after intubation through the tracheostome. Only one paralysed cord is chosen and an incision is made along the whole length of the cord about 2 mm. above and 2 mms. below the edge of the cord. The mucous membrane is then dissected upwards and downwards with fine ophthalmic scissors to form two hinged upper and lower mucosal flaps. Now the subjacent thyroarytenoid and lateral cricoarytenoid muscles are removed along with the arytenoid cartilage by trimming with fine scissors and toothed forceps. An elliptical fossa corresponding to the vocal cord and subjacent tissue is thus obtained. With very sharp curette the bottom of this fossa is curetted vigorously in a posterior anorterior fashion, till the thyroid cartilage is seen shining covered with the endochondrium. Any remaining muscle is removed meticulously with the use of a magnifying Loupe. The upper and lower mucosal flaps after suitable trimming are replaced to form a continuous lining in the depth of the fossa. The larynx is packed with sterile vaseline gauge and brought out through the upper end of the tracheostomy opening. The laryngo-fissure wound is closed by suturing and a tracheostomy tube is applied in the tracheostome. The laryngeal packing is removed slowly in the course of 4 days by pulling out short lengths of the packing daily through the upper end of the tracheostome and cutting the same.

I have done a total of 5 cases in all by this method in cases of bilateral abductor paralysis, where one was referred by Neuro-surgeon as occurring following removal of an intracranial tumour and the four others following thyroidectomy.

In this method there are a few points to consider, which I feel are important.

In devising this operation we seriously took into account the causes for failure in the previous chordotomy and chordectomy procedures. It is an axiom in larynx that if the mucous membrane is damaged and if a portion of the muscular tissue is left behind these will react with severe scar tissue formation making voice poor and causing symptoms as dis-