LETTER TO THE EDITORS

THE EDITORS,

The Journal of Laryngology and Otology.

DEAR SIRS,—Mr Mark Hovell contributes to your issue for October a plea for the partial removal of the tonsils, which calls for a reply from one of those who hold a different opinion. He bases his argument largely on the cases in which enlarged but healthy tonsils are present in children suffering from nasal obstruction due to adenoids, and states that such cases form the majority in children, that the enlargement is the result of the nasal obstruction, and that the tonsillar tissue contracts when free nasal respiration has been restored. If that be so, the logical treatment would be to remove the adenoids and to leave the tonsils to shrink untouched.

I do not find, however, that the majority of enlarged tonsils in children are healthy; on the contrary, in most cases the glands below the angle of the jaw can be felt to be slightly enlarged, showing some degree of septic absorption, and a large number suffer from attacks of tonsillitis. Numerous examinations of removed tonsils might be quoted in support of the above, and it has frequently been demonstrated that in chronic inflammation the deep part of the tonsil is involved as much as the superficial portion. I hold, therefore, that if removal of any part of the tonsil is indicated, then the entire gland should be removed. Mr Hovell makes light of the statement that the edges of the crypts sliced by tonsillotomy are apt to unite and cause retention of secretion; it is certainly a very common experience in my practice to see a severely septic condition in the remnants of tonsils left behind by a previous tonsillotomy.

One often sees a child with symptoms of nasal obstruction due to adenoids, whose tonsils are not enlarged, and who presents no tonsillar symptoms; in such cases it was formerly my practice to remove the adenoids and to leave the tonsils alone; but a considerable number of these children have been brought back to me two or three years later with symptoms of tonsillar inflammation and with enlarged tonsils, although the nasal obstruction has been completely removed, so that I now advise removal of even apparently healthy tonsils when the adenoids call for operation in children below the age of six or seven years. I do not think that the later tonsillar enlargement is due to neglect to remove the posterior ends of the inferior turbinals, for I have long been aware of Mr Hovell's recommendation, and I am prepared to remove the ends when they are enlarged.

I am not clear whether, by the term "enucleation," Mr Hovell refers only to the operation of dissection, or whether he includes

https://doi.org/10.1017/S0022215100022829 Published online by Cambridge University Press

complete removal with the guillotine. Complete removal with the guillotine does not produce any disabling cicatrisation, but I agree with him that the cicatrisation following the dissection operation may be a cause of disability, and I consider that this operation should be reserved for tonsils which cannot be removed entirely with the guillotine. The latter include very small septic tonsils, those fixed by adhesions, and those which have previously been partially removed.

Mr Hovell believes that hæmorrhage is more frequent and more severe after enucleation than after tonsillotomy. I, on the contrary, am convinced that it is less so after complete removal with the guillotine than after partial removal. On theoretical grounds, one would expect bleeding to be less free and persistent when the vessels are divided in the loose areolar tissue beneath the capsule of the tonsil than when they are severed in the firm substance of the tonsil itself, which is often also the seat of chronic inflammation and fibrosis. I have been operating on tonsils and adenoids at St George's Hospital for nearly eighteen years, the majority of the operations being performed in the out-patient department; the patients are seen after two or three hours, and, if there is any anxiety on the score of bleeding, they are admitted. I have no statistics, but my recollection is, that in the days of tonsillotomy, there were some two to four such admissions in each year; now that complete removal with the guillotine is practised, the admissions average less than one a year. The remaining portion of the tonsil frequently becomes swollen and inflamed after tonsillotomy, and I find that healing after complete removal is quicker and less painful, and that there is less liability to aural and other complications. Therefore, on the grounds of safety, of comparatively painless healing, and, above all, of freedom from subsequent tonsillar disease, I advocate complete removal with the guillotine whenever operation on the tonsils is indicated, and dissection only when the local condition makes enucleation with the guillotine impossible.—Yours faithfully,

HAROLD BARWELL, F.R.C.S.

GENERAL NOTES

ROYAL SOCIETY OF MEDICINE,

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Section of Laryngology—President, Sir William Milligan, M.D. *Hon. Secretaries*, W. G. Howarth, F.R.C.S., and T. B. Layton, D.S.O., M.S. The next Meeting of the Section will be held on 2nd December. Members intending to show cases or specimens are

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