ANESTHESIA IN TONSIL AND ADENOID OPERATIONS.*

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It is with some timidity that I bring the subject of anesthesia for the removal of adenoids and tonsils before this section. As I believe that the last word has not been spoken, and inasmuch as our chairman has indicated to me that we are to lay aside formalities and have some heart to heart talks, and because I desire to know and to do the right thing is my apology for introducing this subject.

Some of the points I wish to suggest for discussion are:

1. Is it necessary to use a general anesthesia in all or the majority of operations for adenoids and tonsils?
2. If so, what is to be the choice of an anesthetic?
3. Cannot these operations be done just as efficiently with less shock and danger to life and post operative complications without a general anesthetic?

It is generally conceded that there is greater danger from anesthesia for operations in the upper respiratory tracts than in other parts of the body; which is doubtless due to the hypersensitiveness and the inhibitory power of the nerve supply to these regions.

The most important point to consider in the choice of an anesthetic is its safety. Anesthesia is a long step toward death. Dr. Holmes once said, "When we take an anesthetic we purchase a round-trip ticket, but not all use the return half." All discussion of this subject must necessarily hinge on the choice and manner of administration.

The details of operation are insignificant compared with the life of the patient. The advocacy of one anesthetic over another because it is easily and quietly given would not suffice for an explanation in case the patient did not survive. The majority that have reached the age of reason, would rather undergo a few moments of suffocation at the start, than quietly go to sleep with an added chance of not awakening.

I am indebted to F. N. Shipp of our city for the following quotation and statistics from a recent valuable paper upon this subject. "F. W. Huitt's statistics covering over a million administrations, show that death resulted once in every 3162 inhalations of chloroform, while with ether, one in every 16,302 proved fatal. He con-

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cludes that chloroform is over five times as dangerous as ether.

"Let those who use chloroform as the anesthetic of choice put this clearly to the patients, tell them that chloroform is easy to take but that the danger from it is five times as great as from the inhalation of ether.

"If all patients were told this and given their choice of anesthetics, chloroform would be seldom used except in those few cases where ether is contraindicated."

Of the various substances that have been used for anesthesia, the great majority of the profession has practically settled down to the employment of ether and chloroform.

Experience seems to indicate that there are no other agents which act so well as these two liquids. Ethyl chloride is being used to a considerable extent. Potter gives a death rate for its use of one in 1500. Ware collected 11,207 cases of its use with one death. Wilcox claims ethyl chloride to be as safe as nitrous oxide gas. If we accept statistics we must give ether the preference.

Some argue that chloroform is safer with children, and practice giving it to children under the age of ten. According to recent observations this view is erroneous.

Three methods of administering ether are in use, namely: Allis type, the nitrous oxide ether method, and the more recent open drop method; all of which have their advantages.

The combination of nitrous oxide and ether has the advantage of using less ether, thereby lessening the post-operative complications. This method has the disadvantage of an expensive complicated apparatus which makes it more adapted to hospital use.

A comparison of a large number of cases in which ether was given with inhalers of the Allis Esmark type, with a similar number of cases by the open drop method show that the latter method has much in its favor compared with the former.

The amount of ether used is much less than with the inhaler and the proper mixture of air is assured, which greatly lessens the danger of after complications. The death rate from general anesthesia in these operations should receive more serious consideration. A few years ago, fourteen deaths were reported in England inside of three years. Not long since, eighteen deaths were published from the same cause, by a New York physician whose name I cannot now recall. When this subject is squarely and fairly put to parents they will nearly all, in my experience, tell you that they would prefer that their child would suffer a few moments' pain rather than be put to sleep and take the added chance that they will not awaken.

In the light of these experiences, I have practiced in a large measure, doing these operations without a general anesthetic, using local and in some cases no anesthetic. With a full appreciation of the criticism that the above statement is likely to bring forth and the belief by some that a thorough operation cannot be done except under general anesthesia I am ready to be put right if convinced my method is wrong.

I believe that in the majority of cases it is possible to do as clean and as thorough an operation with a local as well as with a general anesthetic. In regard to complete removal, it has been observed and demonstrated that recurrence and new growths occur occasionally after all methods of operation.

My custom is to have two assistants: one takes the child on the lap or on the right knee leaning forward against the patient's shoulder grasping the body, arms of patient at sides; feet off the floor if possible. The second assistant grasps the top of the head over the right shoulder of the first assistant. Both hold the patient firmly. A tongue depressor is passed over the tongue touching the pharyngeal wall, when the mouth will at once come wide open, the forceps or curette is then placed in position behind the palate, the tongue depressor is now withdrawn partially or completely so that the child has no obstruction to breathing. The majority of children in this position, if firmly held will struggle but little. The curette is passed high up in the vault and moved about until the mass of the tonsil or adenoid is felt to be grasped. A firm sweep with a little rocking motion will remove the mass. A second and third sweep on the sides will complete the work. If the forceps are used I usually finish with the curette.

These operations should not be discussed in the presence of the patient. I find that with a little preliminary kind treatment the operation can almost be completed before the child realizes what has happened, and they are certainly, with me at least, in better shape than after a general anesthetic.

Practically, the same preparation is carried out in removing tonsils.

There are other points in connection with this subject that might be of interest to all of us which I hope will be brought out in the discussion.

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