THE TECHNIQUE OF TONSILLECTOMY.*

E. C. ELLETT, M.D., MEMPHIS.

By tonsillectomy we understand the complete removal of the tonsil in its capsule, as distinguished from tonsillotomy, or removal of a portion of the gland. The latter has been the operation usually performed, and is still probably more often done than tonsillectomy, though the trend of practice now is toward tonsillectomy. If we regard the tonsils as lymphatic glands, it certainly looks unreasonable to remove only a part of the diseased gland, and leave behind a part equally diseased and incapable of performing any function with which it may have been at one time endowed. It is not intended now to defend removal of the tonsils, except to say that as the result of my own observation I am satisfied that their removal is a proper procedure, and if they are to be removed at all, my opinion is that the gland should be completely removed. We then with certainty do away with recurrent tonsillitis, and eliminate one of the most vulnerable points of entrance for many infectious processes, notably tuberculosis. That there are many practitioners who still decry removal of the tonsils, and attempt to shrink them by treatment, I am well aware, but I am not responsible for their opinions or their results, both of which are doubtless satisfactory to them and to their patients.

As the result of a good deal of operative experience, and a good deal more observation and study of the methods of others, I have finally adopted the following, to me, satisfactory technique:

The patient is anesthetized with ether, if a child. Large children and adults can be operated on under cocaine anesthesia, if suf-

ficient time and care are taken to secure the full effect of the drug.

If under ether, a combination self-retaining mouth gag and tongue depressor is introduced. This gives an excellent exposure of the throat, and leaves both of the operator's hands free. The depression of the tongue occasionally stops the respiration, but in only a few cases have I had to abandon this gag on that account.

With the child's head turned to the right side so the light falls well into the throat, one tonsil is grasped with forceps and pulled about to determine the presence, direction and density of adhesions to the anterior faucial pillar. These are separated by an Ingals separator, or by introducing the point of a pair of scissors (Prince's) and opening them. I do not like a sharp separator, as the blunt ones tear their way along the lines of least resistance, which are the natural planes of separation in this instance, and secure a more accurate separation of the tissues with a minimum of bleeding. Each tonsil is treated this way, it being usually necessary to separate the anterior faucial pillars only, though at times adhesions must be separated above and, very rarely, behind. Gauze sponges are freely used to help keep the throat clear of blood and mucus. I always operate with the patient lying on the right side, and free the right tonsil first, as the bleeding from it does not then obscure the left one.

A Kratzmueller snare is now introduced, and the loop placed in front of the tonsil. Forceps grasp the tonsil and pull it toward the median line through the loop, which is worked

*Read before the West Tennessee Medical and Surgical Association, Jackson, Tenn., May, 1908.

outward at the same time to reach the attachments of the tonsil. Care is necessary to avoid including the uvula or any part of the soft palate in the loop.

When all is in position, the handles of the snare are brought together and the tonsil then separated and removed from the throat with forceps. Examination of the specimen, inspection of the fossa, and exploration of it with forceps and the finger should be used to determine if the entire gland is removed, and any remaining pieces should be picked up and removed the same way.

The left tonsil is similarly treated.

Bleeding is free, but soon ceases.

When one first sees or does this operation the large size of the gland and the large opening left after its removal, are a source of

surprise. This cavity fills up and contracts, so that in a week or ten days it no longer exists.

I have done many tonsillotomies and quite a number of tonsillectomies. Tonsillectomy is the more difficult to do, but there is no more danger of hemorrhage, primary or secondary, in one than in the other. In the cocaine operation, tonsillectomy is followed by decidedly more pain than tonsillotomy, but the better ultimate results more than compensate the patient for the greater immediate pain. The operation of tonsillectomy cannot be followed by further gravity of the tonsil, whereas tonsillotomy often is. My own opinion and my own practice is that this operation is a major one, and should be done in a hospital.

Randolph Building.