TWO UNUSUAL CASES OF HEMORRHAGE FOLLOWING ADENOTOMY AND TONSILLOTOMY.

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Hemorrhage, immediate or secondary, following the removal of tonsils, is an accident liable to occur with any case. Up to the age of ten years, the danger of hemorrhage is at its minimum, and scarcely ever will one be annoyed by this accident when removing tonsils in the very young. This statement must be modified so as not to include patients with the so-called hemorrhagic diathesis.

Hemorrhage to an annoying degree following the removal of adenoids, is still less liable to occur, and yet "all things are possible" even when we think we are most securely fortified. Dr. W. A. Martin, of San Francisco reported in *The Laryngoscope*, of July, 1899, a series of three cases where he was troubled with severe hemorrhage following the removal of adenoids. In all of these cases the operation was performed with the Gottstein curette as is done probably by the majority of operators. Personally, I always prefer the forceps, for I am firmly convinced that you are much more liable to be annoyed with troublesome hemorrhage following the operation when the curette is used than when the forceps are resorted to.

An unique experience with two recent cases, prompts me to report the same:

Case 1. Miss N., age 15, was brought to my office by her mother to find out why her daughter breathed so constantly with her mouth open and was troubled so much with a collection of mucus behind the nose. The patient was a well grown, healthy looking girl with good color. She had a most excellent throat to examine, in that both probe and posterior mirror could be used simultaneously. I found a bunch of adenoid tissue in the nasopharynx which was evidently the source of her trouble. As she had such perfect control of her soft palate, I cocaineized the adenoid tissue, used the suprarenal extract and then removed a small piece

with the post-nasal cutting forceps. There were but a few drops of blood following the operation. Having decided to remove all the adenoid by degrees, the patient was allowed to return home. This was at 11 o'clock a. m. At 2 o'clock I received a telephone message that the patient was bleeding excessively from the throat and with the request that I come out as soon as possible. This I did and found the patient rather weak and pale from the loss of blood. A large clot had formed on the nasopharynx and this hung down below the soft palate. Alongside of this the blood was trickling down. I first tried a solution of the suprarenal extract run through the nose. This was tried faithfully, but without results. I then introduced a soft catheter through the nose and allowed a clot to form around the end in the nasopharynx. This stopped the hemorrhage, and, thinking that if this could continue for a short while, the bleeding would be stopped permanently. I made the catheter fast in the nose and directed the patient to be kept perfectly quiet. This proved to be adequate for two hours at the end of which time I was again summoned for the renewed hemorrhage. I then decided to plug the posterior nasal cavity. This I did twice without result. I then introduced the third tampon, making it as large as possible. In about two minutes after its introduction the patient fainted and it was not until then that the hemorrhage ceased. The patient was kept quiet, fed on liquid diet and at the end of thirty-six hours the plug was removed. No further trouble was experienced and the patient was out again in two weeks.

This patient presented none of those appearances usually found in those of a hemophilic diathesis. On inquiry, I ascertained from the patient's mother that the daughter's monthly period was due at the time of the operation but had not made its appearance. It did so a few hours after the hemorrhage ceased. The question very naturally arises, was this not one of the anomalous cases of vicarious hemorrhage persisting after an exciting cause? The question of secondary hemorrhage following the use of the suprarenal extract also presents itself. I am inclined to the first theory being largely fortified by my previous experiences in the removal of adenoids. Such persistent hemorrhage even after the post-nasal space has been plugged, certainly argues some systemic dyscrasia. In the future I shall certainly always be more careful to inquire as to the catamenial period before attempting any operative procedure.

Case 2. Annie S., age 4, was brought to my office to have her tonsils removed. The engagement for the operation was made on the advice of the family physician, the case never having been seen by me. The tonsils were found to be enormously hypertrophied. The child was apparently well nourished, but pale and exceedingly nervous. The right tonsil was quickly removed with a McKenzie's tonsillotome and was followed by the usual amount of bleeding. By the wishes of the parents one tonsil only was removed. This was done on Saturday, and during the next three days the father telephoned me that the little patient had had absolutely no trouble. On the following Thursday morning early, I was telephoned for to see the patient who had vomited about a pint of bloody grumous material. The blood was clotted and of a bright red color. The mother informed me that there had been a little bleeding on the day previous, but as it did not run out of the mouth she concluded that it was of no consequence. As the child's pulse and general condition seemed good, and no blood appeared at the mouth when head hung over the bed, I ordered the child to be kept in bed, for her to be given cracked ice and ice cream internally and to report if there was any further trouble. Nothing was heard from the patient until 1 o'clock that night, when I was again telephoned that the child had vomited another large amount of blood and was very weak and pale. I found the child asleep on my arrival. The pulse was regular and not unusually rapid. From previous knowledge, I felt that if I attempted to examine the child's throat, the crying, muscular exertion and nervous shock would do more harm than good, and in a child of that age very little could be accomplished locally without the use of a general anesthetic. I then had the child given 1 grain of the powdered extract of the suprarenal capsule every two hours, the whole amount mixed with the second spoonful of ice cream. This to be done for twelve hours, the child in the meantime being kept quiet. Whether such bleeding as was there stopped naturally or was influenced by the suprarenal extract, I do not know. However, we had no further trouble and the child made an uninterrupted recovery.

A case of this kind is always annoying to the laryngologist. Here is an only child, nervous, over-indulged by anxious parents and going into violent spasms of screaming on the least attempt to look at the throat. Mild expectant treatment in cases of this kind is certainly the best discretion when the physical signs show

no alarming conditions present. I have searched carefully in the various text books and literature, for any reference to similar cases, but have been unable to find even a reference. Naturally, one might say in reference to the first case that no one should operate during the climacteric period, and yet few of us are always careful enough to inquire into the physical state of the patient when about to remove a small piece of adenoid tissue. Such an experience as the above should certainly warn us of this possible concomitant danger, and reference to it should at least be made in those text-books which pretend to be a complete guide to its readers.

In the first case the interest centers in the fact that secondary hemorrhage occurred five days after the operation of removing the tonsil, an interval longer than any I have found in the literature bearing upon the subject. Then, again, the fact of the hemorrhage taking place in a patient so young is unique in itself. We find cases reported of secondary hemorrhage in the adult, but none where the patient was so young as the above.

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"On the Use of A. C. E. Mixture and Ethyl Bromide For Adenoid Operations."—J. W. GLEITSMANN, *Medical Record*, Dec. 2, 1901.

Since 1894 the author has employed ethyl bromide for the production of anesthesia in these operations, and prefers it to any of the other anesthetics for short operations. The operation is performed in the upright position, with the aid of two trained assistants.

When the A. C. E. mixture was given, the anesthetic was started with the patient in the recumbent position, and after the patient was thoroughly under its influence, the child was gradually raised to the upright position.

Though extensively employed by the author he had but one accident (attack of suspended respiration), due to a tight band of a skirt which had not been removed. The child promptly recovered by the use of the ordinary methods. At present the ethyl bromide is used by the author almost exclusively with pleasant results. An air-tight mask should be employed and this should be pressed firmly on the child's nose and mouth. Merck's one-ounce glass tubes are recommended, as they give very little waste. (The abstractor can testify to the sense of security one feels in administering this prompt and safe anesthetic.)

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