

CONCLUSIONS.

The preceding is by no means offered as anything but a synopsis of the irrigation treatment of uncomplicated acute gonorrhea, which elsewhere¹ has been exhaustively detailed. However, it is believed that enough has been said, at least in a suggestive way, to warrant offering the following conclusions:

1. Every general practitioner is perfectly competent to treat successfully uncomplicated anterior gonorrhea, if he will devote as much attention to this as he does to any one other disease.

2. Every patient with gonorrhea is entitled to the services of his family physician, just as much as if he had acquired any other disease in consequence of drunkenness or other violation of ethics or morals.

3. The general practitioner who declines to treat uncomplicated acute anterior gonorrhea avoids one of his most sacred duties to the profession and to humanity.

4. The patient who, because of his gonorrhea, is refused the services of his physician, is likely to become an opponent to scientific medicine, to the detriment of his health, that of his family and of the community.

5. The scientific treatment of at least acute anterior uncomplicated gonorrhea, is perfectly within the power of the general practitioner.

6. The irrigation treatment of gonorrhea is, as yet, the most effective method and most in accord with the modern scientific understanding of the disease.

OPERATIVE TREATMENT OF THE FAUCIAL TONSILS

WITH A VIEW TO THE PREVENTION OF CERVICAL ADENITIS.*

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The recognition of the interdependence of the tonsils and pathologic conditions in other, sometimes remotely situated parts of the body, represents one of the important advances in medicine during recent decades. A variety of diseases have been traced to a primary involvement of the tonsils, and among them are rheumatism, septic infection, tuberculosis, and in a recent report¹ appendicitis and infectious jaundice.

The anatomic structure of the tonsil predisposes to the entrance of the bacilli, for the covering epithelium is always porous, owing to the constant migration of leucocytes, and may be absent over small areas. Microbes usually invade the tonsils through the crypts, which constitute good hiding places and breeding spots. The enlargement and the surface irregularities associated with chronic hypertrophy greatly favor infection, and the resistance of the tissues under these conditions is diminished by the accompanying catarrh and the loosening and casting off of the epithelium.

The pathologic condition which is most often referred to primary tonsillar infection is cervical adenitis, whether in the form of simple hyperplasia or tubercular lymphomata. Baumgarten experimentally produced tuberculosis of the tonsils and the adjacent cervical lymph nodes in animals by feeding them with tuber-

culous material. His demonstration that the tonsil was the nidus of infection in tuberculous adenitis was also confirmed by other investigators.

A number of extended autopsy records have been published which show the frequency of tuberculosis of the tonsils in consumptives when tuberculosis of the cervical glands was present.

The danger which diseased tonsils represent as a possible etiologic factor in the production of other lesions has led a number of observers to propose tonsillectomy as a prophylactic measure.

Semon,² in 1885, presented an elaborate report advocating the more frequent recourse to ablation of the tonsils in order to improve debilitated constitutional states, and recommended "a reduction in the size of the tonsils, if the chronic enlargement, though not very considerable, be attended by a tumefaction of the cervical lymph nodes.

Krűckmann³ reports a number of cases where a close connection could be traced between these two conditions, tuberculosis of the tonsils and cervical lymph nodes, sufficient for him to warrant the statement that where tuberculosis of the cervical lymph nodes is operated on attention at the same time should be directed to the tonsils. In fact, where a scrofulous diathesis is suspected, it is always advisable to remove hypertrophied tonsils.

Ruge⁴ says that the tonsils form an important port of entry for the tubercle bacillus, leading to infection, among other organs, of the cervical lymph nodes, and he is inclined to recommend the ablation of hypertrophied tonsils to avoid infection and its consequences. Even when they are already involved, the operation may prevent other infection. In recent text-books and manuals of surgery, the writers often refer to tonsillectomy as a prophylactic measure.

After we admit the necessity for operative treatment, with a view to preventing cervical adenitis, the most important question to be considered is the best and most effective operative treatment for all cases. Ablation or extirpation of the greater part is the thing desired. Those who have given strict attention to the subject feel that the advice that is usually given with regard to tonsillectomy does not cover the ground sufficiently.

The ordinary operation for tonsillectomy with the guillotine is usually effective in removing the part that protrudes. Some method of dissection, clipping, snaring, curettage or gouging seems to be necessary to relieve those cases in which the tonsil is deeply submerged or hypertrophied in its obscure parts. And it is these obscure parts that convey the septic material in chronic cases to the lymphatic glands of the neck and general circulation. It is to these deeper parts of the crypts and the base of the tonsil that I wish specially to call attention. Anyone who has not had extensive experience can not appreciate the difficulties that are met with in a series of hundreds of cases. The tonsillar mass frequently extends from one-half to three-fourths of an inch, or even an inch outward into the walls of the throat and mouth with a large curtain composed of the opercular folds and the mucous membrane covering the anterior surface. The writer has spent much time and thought trying to devise serviceable instruments for this operation. He has used almost everything that has been

1. The Irrigation Treatment of Gonorrhea; Its Local Complications and Sequelæ. William Wood & Co., New York.

* Read at the Fifty-fifth Annual Session of the American Medical Association, in the Section on Laryngology and Otology, and approved for publication by the Executive Committee: Drs. G. Hudson Makuen, George L. Richards and John F. Barnhill.

1. Forchheimer: Archives of Pediatrics, 1902, p. 656.

2. Semon: St. Thomas' Hospital Reports, 1885, vol. xiii.

3. Krűckmann: Virchow's Archiv, 1894, vol. cxxxvii, p. 534.

4. Ruge: Virchow's Arch., 1896, vol. cxliv, p. 431. Schenker: Virchow's Archiv., vol. cxxxiv (autopsies).

suggested by others, as well as those he has constructed. He finds that numerous instruments are needed for safe and proper removal of this tissue in the different cases that present so many individual features. If the tonsil is peculiarly situated and can be drawn out by engaging forceps, and the old Physick guillotine used after having been properly adjusted, the result is perfect. But this can apply to only a limited number of cases. Usually it is necessary to grasp the tonsil with a pair of forceps and carefully cut it loose from its capsular sheath, when, after traction with the forceps has been employed, the adjustment of a strong wire snare or a guillotine is made. Frequently bleeding, gagging, vomiting, pain or a terrorized condition of the patient will interfere with this method, then some form of the punch forceps can be effectively used through the above-mentioned interfering manifestations.

I have a tonsillar curette made of razor steel, well sharpened, which I have found most valuable for removing the masses at the bottom of the cavities, which have been left after using the guillotine snare and punch forceps. In many cases it is better to sacrifice the opercular fold and a part of the mucous membrane that covers the faucial tonsil anteriorly. This procedure frequently materially aids one in "biting" out the deeper masses with the punch forceps.

I have a self-threading and unthreading needle for drawing the tonsil out of its bed; in some cases it will be found more practical than the forceps, as it does not need readjusting in cases of bleeding or vomiting. In addition to a solution of 100 per cent. locally I use a limited amount of solution of cocaine, from 1 to 10 of 1 per cent. hypodermically, to be followed by free injections of sterilized water into the adjacent tissues. It is my custom to do the operation with or without general anesthesia. When it has to be done under general anesthesia I have found the most feasible position of the patient is on the side with the head hanging over the edge of a high table, so that the operator can remove the sunken part of the upper tonsil and let the blood flow out at the lower angle of the opposite side of the mouth. I have noticed that the tonsillar capsule can be involuted by traction, and that in this position the cauliflower-like masses can be rapidly removed with the biting forceps or the snare.

There are two points that I would like to emphasize: First, that the cervical lymph nodes can be read with our fingers and considered as an index to pathologic conditions in the faucial tonsils. Second, that we should not be contented with the old method of tonsillectomy with the guillotine only, but that we should employ the scissors, dissecting knives, traction forceps, thread passed through the tonsil for traction purposes, wire snare, punch forceps or curette, each or all, as careful analysis of the anatomico-pathologic conditions may indicate in each individual case.

In conclusion, I may say that I firmly and conscientiously believe that we owe to childhood the thorough removal of the bases of all tonsils associated with continued and decided cervical lymphoid enlargements.

DISCUSSION.

DR. J. A. STUCKY, Lexington, Ky.—The general profession does not appreciate the importance of tonsillectomy. It has been looked on as one of the simpler operations which anyone could do. To me it is one of the most important and frequently one of the most difficult operations. In following the method suggested by Dr. Myles, I have been surprised in cases where I was unable to get the tonsil entirely out, to find that in thirty

days atrophy of the remaining portion had taken place and there was no tonsillar tissue there. It is astonishing what Nature will do in these cases. I question the wisdom of attempting to do the radical operation in one of these deep pockets without the use of a general anesthetic. It seems to me that it would be very difficult to control the hemorrhage if that should occur. In all cases where we find these deep, submerged tonsils, I think it is safer to use a general anesthetic.

DR. E. PYNCHON, Chicago—The teaching of the paper is absolutely correct as to the thorough removal of a diseased tonsil. If the indication is to remove any part of the tonsil, then the indication is to remove it all. I do not use the biting forceps, but use different methods at different times; in my operations before classes I do this so that the students may observe the different instruments in use. My favorite method is with the electric point, with which I can remove any tonsil. It has the advantage that I am practically working in a bloodless field. In operating on the deep part of the wound, the supratonsillar fossa, I am not operating in a deep hole, because I am all the time pulling the tonsil outward. By use of the electric point and working in this way, I remove the tonsil absolutely, and never have these rough points and holes remaining, which are seen after other methods. After the operation is finished the work is not done; there is a great deal in the after-treatment which is just as important as the operation, as by massage we rub off excessive granulations and stimulate the wound so as to make it heal up smoothly. The cavity between the pillars thus becomes healed and is covered over with a smooth membrane of cicatricial tissue which has the same appearance as that of the roof of the mouth.

DR. O. TYDINGS, Piqua, Ohio—The snare I use is a little different. The instrument maker whom I had make it for me stole the idea from me and has patented it. I have tried the cautery, and I remove the whole tonsil instead of half. In this I make a section and separate the tonsil from the pillars, draw it down with a vulsellum and dissect it out with knives. I use a blunt dissector and with these one can peel out the entire tonsil with very little hemorrhage and remove it absolutely with this snare. I have never seen a tonsil I could not draw though this snare. With these knives I have been able to operate on any tonsil and, except in cases of severe and acute inflammation, with very little hemorrhage.

DR. ROBERT E. MYLES—I admit there is one serious drawback in advocating this operation; it virtually destroys a large portion of the general practitioner's income. All those conditions which are due to sepsis are discontinued, and that is one weighty reason why these tonsils should be removed. One can decide in some doubtful cases whether or not a tonsil should be extirpated by pressing the tongue down, squeezing the tonsil and causing the discharge of an offensive debris from the crypts. I do not think a general anesthetic is necessary in all cases. I seldom use it in adults, but it is frequently necessary in operating on children. As to Dr. Pynchon's practice of removing all the tonsil, I have tried to do it for years in cases where these large masses are found, and my experience has been that it is impossible unless one takes away the circular sheath. We need a certain amount of tonsil and in my judgment should remove only the part which is diseased or abnormal. I appreciate very much Dr. Tyding's point about tearing loose the tissue. The Italians were using the method several hundred years ago.

Rigor Mortis in Stillborn Children.—Dr. C. H. W. Parkinson, in an article in the *British Medical Journal*, brings out a fact probably not generally known, that rigor mortis may and does occur in stillborn children. He reports three cases and states that in one case cadaveric rigidity had clearly obstructed labor and that after delivery the rigidity increased, the legs and arms being drawn up in the position they would have taken within the uterus. Dr. Parkinson calls attention to the importance of the subject from a medicolegal point of view.