

SIMPLIFICATION OF THE SURGICAL TREATMENT OF PERITONSILLAR ABSCESS.

DR. THOMAS H. CATES, Little Rock, Ark.

Though peritonsillar abscess is fraught with serious consequences in only exceptional instances, and we regard the real dangers of the affection as remaining for the most part within the realm of latent possibilities, there are, nevertheless, few maladies in which marked suffering is present to a more constant degree.

Should we not, in any event, give more than mere passing attention to those methods the application of which have proven to most quickly and thoroughly drain the abscess, and so to most materially shorten the period of the extremely annoying symptoms?

It is not the object of this article to present a technique that is new in principle, but rather to urge that greater deference be paid to the anatomic relation of the parts than is the usual custom in dealing with these cases.

By a proper conception of the anatomy with reference to the location of the abscess we not alone are in a position to proceed along better surgical lines, but likewise to simplify matters greatly by very promptly reaching the pocket of pus at the point of origin. On the other hand, a failure to fully comprehend the structure and relation of the tissues in this region, or to properly act upon this knowledge, often leads to disappointing results.

By proceeding in the usual and less rational way we frequently do not strike pus at all at the point first selected, and have to choose another site, or else considerably deepen the original incision, blindly groping, as it were, to reach a space containing pus. And, if successful in this respect, there is no assurance that sufficient drainage will be obtained to satisfy the demands of the case. Consequently, even further incisions are often necessary to gain this end and relieve the greatly distressing symptoms of the patient.

When called upon to treat one of these cases, we generally find the patient complaining of much pain—which may become almost unbearable—dysphagia, and withal of feeling quite ill. It is not unusual to find deglutition so greatly impaired that it is a practical impossibility for the patient to voluntarily take nourishment. And now and then we see a case in which respiration is interfered with to quite a critical extent.

Now, shall we follow the common procedure of sticking a knife in that part of the swelling which appears most prominent or softest, and immediately repeating this painful performance if no pus is discovered? Or, shall we make one incision in this way and then repeat it the following day, should the patient complain of being little or no better, and so on until relief is obtained? This may answer the purpose of effecting a cure by eventually securing adequate drainage; or, there is of course a possibility of promptly affording relief by making one such incision, since this may perchance be sufficient.

However, the observation of the writer has been that this method is largely a "hit or miss" proposition, and that many of these cases which are relieved following an incision of this kind are rendered so, not necessarily by reason of such an incision, but often by a spontaneous rupture of the abscess. Indeed, there is no doubt but that most of these cases would go on to ultimate recovery without any surgical interference whatsoever, either by spontaneous rupture, absorption, or by a combination of these two efforts of nature. But an expectant form of treatment entails needlessly prolonged suffering, with a possible risk of aspiration of the ruptured abscess contents into the larynx with sometimes fatal results.

Again, there is a further uncertainty in the use of the usual method, in that we may be misled into believing that a point of bulging at the upper part of the anterior pillar contains pus, when such a projection is often caused by the tonsil itself being pushed forward and inward by the pus external to the tonsil. And other objections have been properly advanced to the performing of incisions in the soft palate or pillars on the ground that the operator may wound vessels of some size, or injure muscular tissue, so that the after scar will interfere with the action of the palate. Great hemorrhage sometimes follows such a practice.

It is rather surprising that in most all text books advice is given to cut freely through these important structures, and that few of them suggest that a more practical method be used except as a secondary consideration.

The term peritonsillar abscess implies essentially an abscess situated immediately around or exterior to the tonsil, and it is in no sense a misnomer. The only space in which such an abscess can begin is between the tonsil and the structures of the throat with which this organ is in intimate relation; namely, the pillars of the fauces and that part of the lateral wall of the fauces formed by the

superior constrictor muscle. Therefore, it follows that pus will first be found somewhere in a space bounded by these tissues, either just external to the tonsil or in the anterior, posterior or superior tonsillar fossa. It may, and usually does, unless attacked early, extend to neighboring parts, but it obviously cannot be drained so well through those tissues secondarily involved as at the first point of development.

In some cases with extensive swelling it would of course seem advisable to drain at both the primary and secondary foci. And a recent case comes to mind in which the swelling was so great and the landmarks so obscured that it was only practicable at the first sitting to open through the soft palate alone at some distance from the primary location. But if we can choose the point to open, there is no doubt but that in most cases the immediate peritonsillar region is the logical point to select, and that this region is most easily and directly entered somewhere between the tonsil and pillars, whether above or to the side of the tonsil.

In this connection, the late Dr. Ballenger¹ of Chicago some years ago devised an operation by which the tonsil is pulled toward the mid-line of the throat and forward, and after making an incision to separate it from the anterior pillar, as though the tonsil were to be removed, a blunt dissector is passed between the tonsillar capsule and the superior constrictor muscle until the abscess cavity is reached. He states that this method never fails to evacuate the pus, whereas others are inaccurate and are often attended with failure.

Likewise, Carmody and Finnoff² have recently described their method of opening such an abscess, which they claim is in the supratonsillar fossa in the great majority of cases. They object to the use of a knife, but use a forceps, which may be opened to spread the wound after introduction. It is plunged between the pillars at their junction above the tonsil. They state though that pus may not be found in the supratonsillar fossa, and that in this case the forceps should not be withdrawn but made to sweep down into the posterior fossa, and failing to find it there, into the anterior fossa. Some authors have suggested reaching the abscess by entering the supratonsillar fossa with a knife.

Theisen³ advocates dissecting backward until the capsule is reached and removing the upper lobe of the tonsil, which leaves a large triangular opening for drainage.

And H. A. Barnes⁴ recommends tonsillectomy for the cure of quinsy during the acute attack. However, such radical forms of

treatment have not received much favor as yet, not being in accord with generally accepted surgical principles.

Of these less radical methods, Ballenger's would seem to offer the best promise of draining the pus cavity at the most dependent part, and it can be said that it is certain of results if the technique is properly followed.

But, under local anaesthesia this amount of manipulation, especially the traction on the tonsil, in my hands has proven to be very painful in these cases, even when cocain is freely injected into the peritonsillar tissue. And there is some objection to giving a general anaesthetic. Thomson⁵ of London states "in opening a peritonsillar abscess it is dangerous to use any general anaesthetic, even nitrous oxide or a slight degree of chloroform anaesthesia."

A consideration of these points has led me to try, under local anaesthesia, the simple expedient of inserting a semi-sharp tonsil dissector between the anterior pillar and the tonsil, working it outward and slightly backward until it has reached the outer aspect of the tonsil, and then pushing it further backward and somewhat upward between the tonsil and the superior constrictor muscle. No other instrument is used except a tongue depressor; and as for the dissector, I have found Carpenter's to be very well suited to the purpose. I have of late come to prefer the sharper of the two submucous elevators of Freer, which is as a matter of course only semi-sharp, for this operation, having found that the shape and comparatively narrow width of the blade of this instrument favors an easy introduction.

If care is taken to keep the dissector in close contact with the tonsil during the procedure it will usually pass between the capsule of the tonsil and the muscle without difficulty. Should pus not be encountered directly the instrument can be manipulated further upward or backward.

In some instances, and as might be expected in incipient cases, pus may fail to appear at all; but in this event it is usually forced out shortly afterward through this opening by the action of the muscles of the fauces. Of course, one may fail in any case if the dissector is not introduced far enough.

In using this method it is of advantage in some stubborn cases to later reinsert the dissector one or more times into the cavity to greater facilitate drainage. This is as a rule but slightly painful after the first time, even when cocain is not applied.

I usually prepare the field by swabbing a twenty per cent cocain solution on the tonsil and anterior pillar, and between them if

possible, though a greater degree of anaesthesia can be obtained by also injecting a few drops of a weak solution into the peritonsillar region.

After having used this operation for some time, I have found it to be less painful than the others I have tried; it is simple of performance, is attended with little bleeding, and usually affords prompt drainage of the abscess. But whichever method we may decide upon as being most applicable to a given case, let us at least endeavor to base such a decision upon sound anatomic and surgical principles.

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900 Scott street.

Severance of the Chorda Tympani Nerve During Paracentesis in Acute Otitis Media. I. SOBOTKY, *Boston Med. and Surg. Jour.*, Feb. 14, 1918.

A woman of 66 suffering from acute otitis media (right ear) was subjected to paracentesis of the tympanic membrane. Two days later she was examined again and the paracentesis opening was plainly seen, somewhat anterior. She complained of inability to taste and of a feeling of numbness over the right side of the tongue. Probe examination showed insensibility to touch. Tests made with solutions showed absence of taste on the right anterior one-half to two-thirds of the tongue, except possibly at the very tip. Taste was present on the right posterior one-third. Otoscopic examination of the left tympanum showed a thin membrane and the chorda tympani nerve as a faint line situated lower than normal. It may be assumed that the chorda tympani on the right side was also abnormally situated and was severed during the paracentesis.

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