

EYE, EAR, NOSE AND THROAT

A NEW TONSIL GUILLOTINE*

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In 1910, I presented to the American Medical Association "A Method of Tonsillectomy by Means of a Guillotine and the Alveolar Eminence of the Mandible."

The guillotine employed for that purpose was the original model of Physic, merely strengthened in its shaft.

Since that time Dr. Stanton Friedberg,¹ of Chicago, in a beautiful historical sketch, has shown us that a guillotine for the removal of tonsils, consisting of a shaft fenestra and a blade to push across, is an ancient device dating from the sixteenth century.

They all have in common the fenestra and the blade to cross it. Such was the model of Physic, and such is the instrument that I have preferred.

I present to you today a lever attachment for the purpose of adding power to

The guillotine, in 1910, was shown to be an instrument adaptable for tonsillectomy as well as for the original tonsillectomy. Since then a considerable number of so-styled improvements added to the guillotine have been made public. Many of these instruments have advantages of one kind or another. None, however, has the advantage of remaining perfectly still within the grasp of the surgeon's fingers while the lever or power device is put into effect.

Three or four years ago, in order to maintain the original model of the guillotine and still add a power lever, I published a "Mechanic's Dog" to be attached. That also has the disadvantage of necessitating the loosening of the surgeon's fingers, to a greater or lesser extent, in the process of adjustment.

The lever that I present to you today has the advantages that are lacked by all of the other devices, to-wit:

The original model of the guillotine is maintained, and at the same time the lever for power may be thrown into service without in any way dislocating the surgeon's grip upon the instrument. That permits some of the capsule to slip and be button-holed.

The accompanying illustration is practically self-explanatory. It shows the guillotine with the lever thrown up under the surgeon's thumb for the final bite.

When the lever is not in use it lies flat upon the shaft of the instrument, and the movement of the blade is left unimpeded in its passage across the fenestra. The

push the blade across the last remnant of tonsil tissue as it is caught in the fenestra.

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¹Annals of Otolaryngology and Laryngology, 1913.



lever bites only when the blade has been shut ready for cutting the last shred. A dull blade is employed and no power device has so far succeeded in driving the dull blade through the last shred of the tissue.

This one does not accomplish that, either. It does, however, drive the blade through the main mass of tissue and leaves only a few shreds to be stripped off with the surgeon's finger.

The lever is held in place by a screw joint which should be adjusted tightly. When this joint is tight the lever may be raised up into position for the necessary biting and will remain fixed in that position while the surgeon performs the stripping of the last shreds.

It will be found a great convenience to have the lever remain in biting position without the attention of the surgeon's being kept specially on it. The surgeon should be enough of a mechanic to tighten this screw should the joint work loose.

Someone will probably "improve" the lever by adding a ratchet to hold it in biting position. This has seemed to me unnecessary and disadvantageous.

I explained in detail the advantages of the original model (simple) guillotine in the *Journal of the American Medical Association*, December 30, 1916.

SOME RARE COMPLICATIONS OF ACUTE MASTODONITIS WITH UNUSUAL SYMPTOMS*

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The writer does not in this paper wish to give the impression that he considers cerebral complications rare in mastoid involvement. In fact, they are rather common. However, it has been impossible to find any record of a case developing so suddenly and with such severe onset as the one to be reported. In looking over records in the Charity Hospital of Louisiana I was able to find in the past seven years records of seven cerebral abscesses from various causes. All the patients died either before or after operation. Two other cases I saw in other hospitals of the city both died. Dr. J. W. Murphy, of Cincinnati, reported five cases seen by himself in one year, all following suppurating ears. In all of these cases the

abscess was found either at operation or post-mortem. This is certainly a large number of cases for one man to see in such a short time when we consider that the records in the large Charity Hospital of New Orleans show only seven cases recognized in the past seven years.

The portion of the brain most likely to be involved from middle ear infection depends often upon the manner in which the infection gains entrance. When it occurs by direct continuity, the temporo-sphenoidal lobe is most often the seat of abscess. When the extension is through the labyrinth, the abscess is most often on the anterior aspect of the cerebellum. Since abscess of the brain of otic origin is a secondary and not a primary disease, the problem of diagnosis is often masked by the primary disease, or some of its complications. Quite a large extradural abscess may be present with little or no symptoms. A cerebral abscess of otic origin being an acute infection, the time is generally too short for the pathognomonic eye symptoms to develop, as in the case of tumors of the brain. Hence, the absence of optic neuritis does not exclude cerebral abscess.

It will hardly be necessary to mention here the symptoms of brain abscess as the normal or subnormal temperature, slow pulse, slow respiration, slow cerebration and want of sustained attention, mental obscuration, and tendency to doze, are too well known to all. Often, however, we may have an abscess with very few of the above symptoms, and these are the cases that give us most trouble.

When the abscess is in the cerebellum, the respirations are much slower than when in the temporo-sphenoidal lobe, are more apt to be irregular and of the Cheyne-Stokes character.

As to the treatment, once a diagnosis is made, the only treatment is incision, and the sooner the better. As to the method of incision, there is some difference of opinion. Some men use a long cataract knife, claiming that because of its thinness there is a minimum amount of trauma and because of its sharpness it readily pierces a tough capsule. Others use a blunt grooved director. Should there be a sinus showing pus, the ophthalmoscope is very useful. Once the abscess cavity

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