

Dr. H. J. DAVIS said that just before the Boston meeting he was afflicted with a similar case, but somewhat worse than this. He took photographs of the case over to Boston and asked the opinions of several as to what should be done. Some said it should be cut off, others that it should be left alone. The hernia was as large as an apple. Mr. Ballance advised him to leave it alone and it would disappear. When he got back it was healed over. He would show the case at the next meeting.

Dr. MILLIGAN suggested that graduated pressure should be applied to the hernia by means of a lead plate. Repeated lumbar punctures might assist the result.

Dr. PETERS said it might be possible to use celluloid collodion, which could be supplemented by lumbar puncture. That failing, pressure could be made as Dr. Milligan advised.

Mr. HUNTER TOD remarked that cerebral hernia did not always disappear if left alone. Several years ago he showed a boy with a large cerebral hernia with granulations. Some advised that it be cut off; others said pressure should be applied. He did nothing. Later the boy got erysipelas, and after that the skin grew over it, but the hernia had remained. Otherwise the boy was quite well. In the cases in which he had tried to remove the hernia he found the skin very closely adherent to the surface of the hernia. In one case the patient died soon afterwards from meningitis. In another case, in which he was successful, he separated the skin from the edge of the hernia and exposed its bony margin. More bone was removed, so as to make the opening into the skull larger, but the dura mater was not injured. With regard to Mr. Mollison's case, Mr. Tod did not advise anything being done at present, as the wound was still somewhat septic.

The PRESIDENT remarked that it had been said that if there was a hernia owing to a hole in the skull, the best way to get rid of it was to make the hole larger. This probably conveyed a germ of truth, for a decompression operation in another part of the skull would relieve it if there were symptoms. As there were no symptoms in the present case it was scarcely worth while to run the risks of trauma which an operation might involve.

Abstracts.

THE PHARYNGEAL TONSIL.

Mackenzie, John R.—*The Massacre of the Tonsil.* "Maryland Medical Journal," September, 1912.

There has probably been no paper recently published on this side of the Atlantic that has been more widely discussed or more frequently reproduced in medical literature. The author has been induced to write the paper as a formal protest against the indiscriminate and wholesale removal of tonsils, which, he says, is the chief and most glaring abuse to the laryngology of the day. Furthermore, he considers this protest is in the interest of the public health and public safety. He agrees that there are hosts of conditions that call for more or less complete destruction of

the tonsils. His contention is that in the selection of cases for operation one should be guided by a sane and safe conservatism and common-sense.

Mackenzie speaks of the tonsil question as never having been in the history of medicine such a lust for operation. He speaks of it not simply as a surgical thirst, but as a mania, a madness, an obsession. He considers the question of operation on the tonsil from the following standpoints:

(1) The functions of the tonsils are in the present state of our knowledge unknown.

(2) Whatever its functions might be—and the production of leucocytes is undoubtedly one of them—the tonsil is not, as is generally taught and believed, a lymphatic gland. He is inclined to agree with Jacobi that it may assume the rôle of the thymus after birth, or when the latter gland ceases to functionate or disappears.

(3) The rôle of the tonsils as portals of infection, like all new doctrines in medicine, has been greatly exaggerated. Too little attention is paid, Mackenzie thinks, to the other regions in the upper respiratory tract in considering the avenues of infection.

(4) The hypertrophied lymphatic tissue of the vault of the pharynx (adenoids) does harm chiefly through obstruction. Restore normal respiration in the child, and in a large number of cases the tonsils will take care of themselves.

(5) The mere size of the tonsil is of itself no indication for removal, except it be large enough or diseased sufficiently to interfere with respiration, speech, or deglutition, in which case it, or a sufficient portion, should be taken away without delay.

The lesson the author wishes to give is that if in infancy and childhood we pay more attention to the neglected nasal cavities and teeth, we will have less tonsil disease and fewer tonsil operations.

Perry Goldsmith.

Wilson, J. Gordon.—The Tonsils in Childhood. “Amer. Journ. Dis. Child.,” May, 1912, p. 277.

In the controversy of tonsillotomy *versus* tonsillectomy the author ranges himself on the side of the conservatives, because he considers that the tonsils subserve a special function, and this he bases on the following circumstances:

(1) The palatine tonsil is present in nearly all mammals, and the organ always contains a channel communicating with the pharynx.

(2) Developmentally the tonsil is not a simple lymph-node.

(3) In addition to the well-known theory of the tonsils being the source of the “salivary corpuscles,” the author claims for them a metabolic function, without, however, suggesting what this metabolic process may be.

(4) Anatomically, the tonsil passes through a period of activity during developmental life, and there is, therefore, no evidence for the supposition that in man it is a recessive organ.

(5) Finally, the author doubts the statement that complete enucleation is not followed by any local or general disturbances. He calls for more careful and accurate investigations on this point.

[The paper is suggestive rather than convincing, and should be read in its entirety.—*Abs.*]

Dan McKenzie.

Swaine, H. L.—Are Tonsils a Menace or a Protection? “Annals of Otolaryngology,” etc., vol. xx, p. 545.

Swain concludes: (1) That logically tonsil tissue must have a function, and if so, it is to the young that it is of most value. (2) If it is necessary to operate in children on the faucial tonsils, which are merely large and not diseased, then there are surely perfectly safe, sane, and effective methods other than complete tonsillectomy to deal with the problem. Be thorough with the adenoids, but save some healthy tonsil tissue. (3) In adults, when the tonsil is diseased, radical procedure is justifiable. *Macleod Yearsley.*

Scheppegrall, W.—The Tonsils and General Health. “New Orleans Med. and Surg. Journ.,” July, 1912.

After briefly describing the anatomy and physiology of the tonsil, the author gives a general *resumé* of the pathology, and indicates the principles of treatment. The tonsil is claimed to be the most frequent seat of the initial lesion in diphtheria, especially when unhealthy the bacillus may remain in the crypts and cause recurrent tonsillitis, when no culture can be prepared from the surface. Tubercular infection is by no means infrequent, and Baup is quoted as giving the percentage of tuberculous tonsils as 6. Many cases of nephritis consecutive to tonsillar infection have been traced to the diplococci of Fraenkel, which may be found in the urine. Occasionally a considerable interval occurs between the tonsillitis and the renal infection.

A severe epidemic of tonsillitis in Baltimore last January is briefly noticed; this was thought to be due to pneumococcic infection, and was marked by a great tendency to inflammatory complications in various organs.

The author is strongly in favour of enucleation of the tonsil when removal is desirable, being of opinion that tonsillotomy or slitting of the crypts may, by causing cicatricial contraction, merely aggravate the evil.

Knowles Renshaw.

Fetterolf, A.—The Anatomy and Relations of the Tonsil in the Hardened Body, with Special Reference to the Proper Conception of the Plica Triangularis. The Principles and Practice of Tonsil Enucleation as based thereon. “Amer. Journ. Med. Sci.,” July, 1912.

The writer lays great stress on the importance in operations on the tonsil of the complete removal of the whole structure, in spite of “the occasional brilliant clinical result of an incomplete operation.” He is opposed to all so-called “one instrument” operations, but admits that he has seen no cases operated on by the Sluder, Ballenger, or Beck instruments. From the observations which he has made on the anatomy of the tonsil and surrounding parts he has endeavoured to deduce the most efficient method of operating. He regards the plica triangularis as the key to the situation. This structure has always hitherto been described as a fold of mucous-membrane; this, the author is convinced, is an error of omission. “The plica triangularis,” he states, “is fundamentally that portion of the tonsil capsule which extends inward and backward beyond the anterior pillar of the fauces.” Thus, if it is not attached throughout to the tonsil, that aspect of it which presents toward the latter is likely to have a more or less thick layer of lymphoid tissue between the fibrous and deep mucous layers, resembling

in this respect any other portion of the capsule. Hence, whether in any given case the plica is "free" or "attached" depends merely on the presence or absence of a fossa or crypt external to it, to which the writer gives the name of "anterior tonsillar fossa." This is, of course, distinct from the "superior tonsillar fossa," which he agrees with Fraser in regarding as also intra-capsular. The plica being therefore essentially a part of the capsule, it is of the greatest importance in commencing enucleation to divide only its mucous membrane covering; if its fibrous tissue constituent, which represents the tonsillar capsule, be penetrated, the subsequent dissection will be carried out in the substance of the tonsil, some of which together with the capsule will necessarily be left behind.

Separation is to be effected by blunt instruments and the finger only; sharp instruments are liable to penetrate the capsule, and are actually dangerous if used for separating the tonsil from the posterior wall of the recess because of the presence in this situation of the largest vein of the tonsillar plexus.

The author's method of operation is described at length, the procedure being divided into fifteen stages for the removal of each tonsil. He has employed it with complete success in 200 cases. *Thomas Guthrie.*

Eppinger, A.—Tonsillectomy in Acute Nephritis. "Wien.klin. Woch.," No. 24, 1912.

Acute nephritis frequently follows an apparently simple sore throat, and though this usually passes off in a short time it may become chronic. The progress of the nephritis in such cases is insidious. The principal symptoms are albuminuria and hæmaturia, and an early rise of blood-pressure; but they are not marked, and the case may easily drift on unnoticed to the condition known as secondary contracted kidney. The author describes three recent cases of acute nephritis after tonsillitis, which had all been treated for several months without any improvement. In every case the tonsils were enlarged and fissured, but externally they appeared otherwise healthy. On excising them, however, small collections of evil-smelling pus containing streptococci were found in their deeper layers. Immediately after the extirpation of the tonsils, the acute nephritis, which had withstood treatment for so many months, began to improve, and within a few weeks the urine was free from blood and albumen. The author recommends that in all cases of nephritis with enlarged and fissured tonsils the effect of tonsillectomy should be tried. *Dan McKenzie.*

Kahn, H.—Quinine and Urea Hydrochloride Solution as a Local Anæsthetic for Tonsillectomy. "Therapeutic Gazette," No. 7, July 15, 1912.

The author thinks quinine and urea hydrochloride 1 per cent. comes nearer the ideal local anæsthetic for tonsillectomy than any other so far introduced. It is non-toxic in the dosage required, non-irritating, and reduces the danger of hæmorrhage.

The patient is given a full meal shortly before the operation, as the drug then acts better, and also after the operation there is dysphagia for a few days.

The tonsils, etc., are first swabbed with 20 per cent. cocaine hydrochloride. The quinine and urea solution is then injected into the supra-tonsillar space, anterior and posterior pillars and into the tonsil. Not less than 45 to 60 minims are injected for each tonsil. An interval of ten

to fifteen minutes is allowed to elapse before operating. An assistant is required to hold a tongue depressor. The tonsil is dissected from the anterior pillar from above downwards, it is then seized with forceps and pulled forwards, while it is shelled out of its bed; a snare is passed over the tonsil and tightened till it cuts through the remaining attachments.

Knowles Renshaw.

Koplik (New York).—Infections following Tonsillotomy, with a Consideration of the Forms of such Infections. "Amer. Journ. Med. Sci.," July, 1912.

Having referred to the various infective processes of which the tonsil *in situ* is regarded as the port of entry, the author remarks that operative measures such as tonsillotomy or enucleation must open up a still larger area to the risk of infection. He has observed that after these operations certain forms of infection are apt to arise, and he expresses surprise that those whose work lies in this field of surgery are not impressed with this danger.

Three distinct varieties of septic infection following removal of the tonsils have been observed by the author: (1) The form in which there is obscure fever for a week or more without any endocarditis or other lesions. (2) Those cases in which fever is accompanied by endocarditis of either a mild or a malignant type. (3) A form in which the infection is evidently severely hæmatogenous and causes destructive blood changes, with signs of sepsis, such as profuse hæmorrhagic ecchymotic areas on the surface of the skin, petechiæ, severe hæmorrhages from the bowel, and areas of broncho-pneumonia.

Thomas Guthrie.

E. A. R.

Kopetzky, Samuel J., M.D.—Meningitis: Its Nature, Cause, Diagnosis, and Principles of Surgical Relief. "Laryngoscope," June, 1912.

The factors underlying the clinical picture are the same in all types of meningitis. The toxic effects from infection of the fluids and tissues of the central nervous system are due to the same tissue reactions whatever the invading organism. As a result of this invasion the available carbohydrate in the spinal fluid is early used up and disappears. This disappearance of the copper-reducing body, excepting in the slowly developing tuberculous infections, is probably the earlier sign of the activity of bacteria in the central nervous system. An early means of diagnosis is thus afforded in cases of suspected meningeal infection, which clearly differentiates meningitis from all other diseases with similar clinical symptoms. Thus, the author found that in thirty-four specimens of cerebro-spinal fluid from cases with meningeal symptoms, but no meningitis, copper reduction was present in all, whilst it was absent in all of thirteen cases with acute meningitis, either otitic, meningococcic, or tuberculous. Owing to some previously undetermined primary factor in meningitis a vicious circle is set up. On the one hand an increased amount of cerebro-spinal fluid, and on the other œdema of the brain and meningeal tissues, act in the limited space of the cranial vault, and exert a compression force on the blood supply, therefore tending to increase the œdema. The author suggests that this primary factor may be the using up of certain constituents of the cerebro-spinal fluid by the organisms as dietary, thus altering its tension and preventing its normal permeation through the membranes of the Pacchionian bodies into the venous blood-