TONSILLAR HÆMORRHAGE.

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OPERATIONS for the removal of tonsils are, I believe, unique in one respect in surgery—viz., in the almost entire neglect shown by the majority of operators to adopt the ordinary means for the arrest of hæmorrhage such as is employed in other parts of the body. At a later date, history will refer to this omission in scathing terms. This has been largely brought about by the fact that incomplete removal has been and is being practised by general surgeons with almost complete satisfaction to themselves.

Another point on which I must comment and which amounts almost to a fetish is the desire to perform the operation in the shortest possible period, no matter what after-trouble ensues.

I have for several years past adopted a very definite procedure, and I never commence to remove the second tonsil until the surface occupied by the first is absolutely dry; I always point out this to my anæsthetist. I employ a very light anæsthesia with coughing reflex always present, the child or adult lying comfortably flat: the mouth is kept open by a Ferguson gag and care is taken never to over-gag. The tongue is never fixed. I take it that, given a patient over-gagged, deeply anæsthetised, with tongue fixed, then all the elements of disaster are present. Having secured my tonsil with forceps (I use a uterine tenaculum), I make one clean incision which does not include the plica triangularis. I complete quickly the separation of the capsule with knife or finger, place a pair of Kocher forceps upon the tissues below and divide with scissors. I then place a large pad of gauze in the cavity and hold the same in position with my forefinger. The anæsthetist now gives a little more, preparatory to the next stage, viz.—searching for the spouting artery or arteries. For this purpose I am convinced there is only one light and that is a direct searchlight. I have again and again detected a vessel unseen by the reflected light. I always use my throat lamp, made by Allen & Hanbury; its simplicity commends itself. It consists of a flattened metal tube through which pass the wires to a lamp at one end and battery at the other. The lamp should be of $4\frac{1}{2}$ volts with a

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white background; this is important, otherwise some light is thrown back upon the observer. (Such lamps are sold at every electrical shop, with battery to correspond.) I remove the swab, place the lamp right down the back of the tongue, and with Kocher forceps secure any bleeding spot. Long use makes one very quick at detecting the source. Upon an average I use two forceps for each tonsil. If the surface is shining from blood, though not extensively, I know that the same may eventually cause a big clot. I therefore search for the offending vessel, which is usually just behind the anterior pillar. An appearance resembling strings of fibrin stretching across the cavity is frequently found to be due to spouting arteries.

Having made quite certain that the surface is now perfectly dry, I apply a swab of compound tincture of Benzoin—wait a few minutes, and then proceed to remove the other tonsil. I remove adenoids with my scissors and also apply pressure and dress the surface.

I am more than convinced that many of the cases of pharyngeal trouble of later years can be traced to the severe laceration caused by the curette in careless hands.

In conclusion, I am convinced that the procedure of sewing the pillars together for the control of hæmorrhage, either surface to surface or over gauze (soon to become septic), is unsound surgery, and that hæmostatic machines should never be used. The correct surgical procedure is to secure the vessel.

I do, however, advocate and now practise, as a routine, the sewing together of the loose mucous membrane covering the pillars in the adult, which is quite a different matter. This operation reduces the pain and subsequent local swelling almost to a minimum.

I bring the membrane together upon each side with one mattress suture. I use No. 1 stained catgut, Reverdin's needle, and my simple catgut-holder. Although the membrane will now appear to be stretched across the exposed muscular surface, contact by swelling soon takes place in the adult. If, however, all hæmorrhage has not been previously controlled, the reverse will take place and a large hæmatoma result. The mucous membrane, it need hardly be added, requires careful handling, although not so readily lacerated in the adult as in the child. I use a mattress suture, and obtain admirable results, being careful to see that the soft palate is quite even at the conclusion of the operation.

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