THE RISKS AFTER OPERATION FOR TONSILS AND ADENOIDS IN OUTDOOR CLINICS.*

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THE removal of tonsils and adenoids in children is, if we exclude dental extractions, the commonest surgical operation done under general anaesthesia; its benefits in thousands of cases each year are considerable and lasting, and its risks, if a very few ordinary precautions are observed, are inconsiderable. With the present congestion of hospital beds, many children who require this treatment would be denied it were not the practice of operating in the out-patient department maintained. The precautions taken at the Bristol Royal Infirmary, from which clinic I have obtained my figures, are as follows: The cases are carefully selected. No sickly child, no child from an "epidemic" district, no child living outside Bristol itself, is dealt with in the out-patient department. The parents are given printed instructions for use before and after operation. The essential preparation is that the child's stomach be empty; it is therefore ordered a fluid breakfast three hours before the operation. It is brought to the Infirmary in the middle of the morning, and the operation is performed by the assistant surgeon or under his immediate supervision. Gas or ethyl chloride is used; all instruments are sterilized by boiling. The child is inspected at 2 p.m. to make certain it is fit to be taken home. The parents are instructed that it must be well wrapped up, that it must not walk a step, and that it must be kept indoors for four days. Formalin lozenges are given, and the child is seen again on the fifth and twelfth days.

Everything, therefore, lies with the parents, who, in practically every case, are anxious to do all they can for the welfare of their offspring. The preparation for operation is simple, and almost always carried out, but in the after-treatment they are often really handicapped; and it is the after-treatment that tells. For the first forty-eight hours raw gaping wounds in the child's fauces invite the attack of bacteria. After that a barrier of granulation tissue exists which will repel all ordinary infection. Mr. Tilley,¹ who likes to keep patients at home for a week after operation, gives as the chief risk of the operation septic infection, which, he says, "is difficult to avoid in hospital practice, where patients often return to their homes within a few hours of the operation"; he records two cases of acute septic poisoning, one fatal, where the home conditions were insanitary.

With the permission of Dr. P. Watson-Williams I have analysed the results of all the cases dealt with at the Bristol Royal Infirmary out-patient clinic during 1919. For the purposes of comparison I have analysed also the last 100 consecutive cases dealt with as in-patients. In both cases only children between the ages of 3 and 15 are included. The in-patients comprise all those admitted because they did not appear robust, and a few cases in which submucous septal resection was done as well. Those cases in which, for example, an antral empyema was opened at the time of the operation have been omitted as being outside the class of minor operations. Otherwise the conditions are similar. The same surgeons operated, and many of the operations on in-patients were actually performed in the out-patient theatre. The only

differences were in the in-patient series: (1) the anaesthetic was usually given by the honorary anaesthetist; (2) ether was sometimes given; (3) the children were kept in hospital for two or three days afterwards.

Such occurrences as severe haemorrhage or collapse have not been included, as possibly they would be more emphasized in the notes of out-patients than those of in-patients. A few histories are appended to indicate the standards used:

Case 3,799 (in-patient).—Following the operation this child had acute suppurative otitis media; the left ear perforated, but healed subsequently; in-patient fifteen days. (Definite morbidity.)

Case 50,144 (out-patient).—This child had double acute otitis media, starting a few days after the operation. The left ear subsided but the right perforated and had not healed when last seen several months later. (Definite morbidity.)

Case 50,782 (out-patient).—The operation was performed on May 30th, 1919. On June 7th the child was admitted with acute mastoid infection; an immediate operation was performed, but meningitis was already marked, and death occurred on June 16th. (Our first fatality directly traced.)

Case 51,298 (out-patient).—The operation was performed on October 10th, 1919; acute mastoid infection occurred shortly afterwards, and Schwartz's operation was done on October 17th. The child was an in-patient four weeks and attended the out-patient department for other ten weeks. The hearing is permanently impaired. (Serious morbidity.)

Case 51,301 (out-patient).—The operation was performed on November 7th, 1919. On November 11th acute suppurative otitis media occurred; myringotomy was performed; broncho-pneumonia followed, and pleural empyema required operation a fortnight later. The child went to the convalescent home three months after the first operation. (Serious morbidity.)

The figures in these tables speak for themselves; though the number of cases is small, nevertheless they afford an important index. The morbidity among children operated on in the out-patient department is over four times as great as among the in-patients. Although the point has been recognized for years, I should like to ask whether sufficient weight is given to it, and what, if any, variation in present practice is desirable.

REFERENCE.

¹ Tilley: *Diseases of Nose and Throat*, 1919, p. 323.

THE DIAGNOSIS OF HYDATID DISEASE OF THE LUNG.

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ALTHOUGH hydatid disease is, apparently, not so common in English clinical practice as it is in Australia, the following brief notes of my experiences of its manifestations in the lung may be of use to English readers.

Between 4 and 70 years is the age limit of my records. There is a noticeable reduction in the number over 50 years of age. Men suffer more than women, and those who dwell in the country more than those who dwell in towns. Australia, New Zealand, the Argentine, and the north-western shores of Europe are the countries most extensively infected. The date of infection has an important bearing on the diagnosis, but those who have once lived in an infected locality may, in doubtful lung affections, be suspect, as the disease may exist for years without symptoms. Constitutional disturbance is unusual, but when it occurs it is not characteristic. Urticaria and maculate rashes are complications, and they may recur year after year.

Blood changes are those common to other parasitic diseases, and consist of an eosinophilia and basophilia. Such changes, however, are not constant, and variations occur from hour to hour. The only well-established fact is that if eosinophilia exists before, it rapidly disappears after operation, and may reappear later to a still greater degree. As a matter of fact, I have rarely found the presence of eosinophilia of material assistance in the diagnosis of obscure cases, notwithstanding statements to the contrary. This problem is complicated because in New Zealand eosinophilia is a very common phenomenon.

There is a conflict of opinion in the literature available as to the value of the precipitin and complement fixation tests. Observations in Sydney, New South Wales, suggest that the results are unreliable, while those in New Zealand confirm this view, but observers in Buenos Aires claim

Table showing Number of Cases and Morbidity.

	100 In-patients, March, 1918, to June, 1920.	239 Out-patients, 1919.	
Definite morbidity — ...	1	7	2.9 %
Serious morbidity	0	3	1.3 %
Mortality	0	1	0.4 %
Total morbidity	1	11	4.6 %

* A paper read before the Bristol Division of the British Medical Association.