HISTORICAL ACCOUNT OF TONSILLECTOMY.

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EXTIRPATION of the tonsils must have been commonly practised at a very early period. The first clear mention of it is made by Celsus (A.D. 10) in his *De Medicina*, cap. vii, sect. 12, but he speaks of excising the tonsils with such familiarity that it was evidently considered a very ordinary procedure. He writes:

Tonsils which remain indurated after inflammation, if covered by a thin membrane, should be loosened by working the finger round them, and then torn out; but when this is not practicable, they should be seized by a hook and excised with a scalpel.

Aetius (A.D. 490) gives the following account of the operation:

The portion which projects—that is, about one-half of the enlarged gland—may be removed; those who extirpate the entire tonsil remove at the same time structures which are perfectly healthy, and in this way give rise to serious haemorrhage.

Paulus Aegineta (A.D. 750) gives precise instructions as to excision of the tonsils.¹ He would not operate on them when inflamed, and describes them as fit for removal when they are white, contracted, and have a narrow base. The head of the patient is held, his tongue pressed down with a spatula by assistants, and the tonsil, being seized and drawn outwards by a tenaculum, is cut out by the root. Albucasis (A.D. 1120) takes Paul of Aegina as his model, and gives the same directions, but he is more cautious in his advice, and dreads haemorrhage.²

After this period the operation became almost obsolete, and succeeding writers omit all mention of it. Even Ambroise Paré (1509) advised tracheotomy where serious enlargement of the tonsils exists.³ Fabricius (1540) believes "the operation is neither easy nor altogether safe."⁴ Guillemeau, the pupil of Ambroise Paré, ligatured or cut away the diseased masses, but did not agree with removal of the entire tonsil.

In 1637 Severini, during an epidemic, removed large portions of the glands by caustics, hook, or semicircular knife; but for a whole century afterwards excision of the tonsils was discountenanced. Dionis (1672) opposed altogether the removal of the tonsils,⁵ while Sharp (1688), a pupil of Cheselden, also feared to excise the tonsils and condemned the operation,⁶ although he removed small portions of the gland by ligature and cautery.

The surgical treatise of Heister was the most popular textbook during the first half of the eighteenth century, and his opinion is as follows:

This operation is not only too severe and cruel, but also too difficult in the performance, to come into the practice of the moderns, because of the obscure situation of the tonsils.

After 1740, however, the operation by means of the tenaculum and the bistoury was again much practised, the credit of the revival being largely due to Wiseman.⁷ His practice was to ligature the tonsils and then to cut off the projecting portion. From 1757, when Caqué commenced to excise tonsils at the Hôtel-Dieu of Rheims, excision of the tonsils became one of the recognized operations of surgery, the dread of haemorrhage being proved to be groundless. Instruments were improved, and new methods invented of performing the operation. Almost every eminent surgeon made some modification of the instruments used for the purpose by his predecessors. The method most generally favoured was to employ a bistoury or pair of scissors, the blades being curved or straight; an assistant pressed down the patient's tongue, the surgeon seized the tonsil with a vulsellum, and, drawing it out, cut off as much of it as he could. As late as 1880 many surgeons still operated with the knife or bistoury, but the guillotine and the wire *écraseur* were then coming into use. A general anaesthetic was seldom given, but sometimes potassium bromide was given in large doses for several days before the operation.

Velpeau (Chassaignac, op. cit., p. 109) reported four cases in which the internal carotid artery was laid open whilst a portion of the tonsil was cut away with the bistoury. About 1875 the common carotid artery was successfully ligatured at the London Hospital for continual

haemorrhage after excision of a tonsil. A tanno-gallic acid gargle was used for persistent oozing, or ice was given to suck,⁸ or marsh-mallow lozenges.

The method of Celsus of tearing out the tonsils by the finger was revived in 1860⁹ by the Italian Borelli, but again deservedly fell into disrepute.

The fear of haemorrhage was a spectre which dogged the steps of all the early operators on the tonsils, but with newer methods of removal and knowledge of the anatomy of the parts, this is a much rarer complication nowadays.

REFERENCES.

¹ New Sydenham Society's Translations, vol. ii, p. 297. ² *Al-Tasrif*, Oxford, 1778, cap. ii, sect. 36. ³ *Œuvres complètes*. Edit. Malgaigne, Paris, 1840, 383. ⁴ *Opera Chirurgica*, 1723. ⁵ *Cours de opérations de chirurgie*, 1714, p. 532. ⁶ *Surgical Operations*, 1761, p. 189. ⁷ *Eighteenth Century Treatises*, 1734, vol. ii, p. 30. ⁸ *Medical Times and Gazette*, 1860, p. 631. ⁹ *Gazzetta Med. Ital.*, Prov. Sard., December 30th, 1861.

OPERATING TO THE CLOCK.¹

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RECENT reports of the treatment of war wounds by Sir Anthony Bowlby and others, in which particular stress has been laid on the necessity for operative rapidity in grave cases, tend to diminish the diffidence which one naturally feels in publishing personal matter, and to strengthen the conviction previously expressed, that more lives may be saved by surgeons "putting themselves under the authority" of the clock than probably has been heretofore generally appreciated.

In operative surgery, as in sport, there are some who focus the situation and put their ideas into action more promptly than others, but this by no means implies that the lightning operator or fast player is necessarily the best exponent.

Celerity in operation, apart from cinema or sleight of hand exhibitions, is, and always must be, sternly subject to one irrefragable law—there must be no scamping of the cardinal principles of surgery. Any infraction, notably inadequate attention to injured blood vessels, interferes with the physiological repair of wounds,² and not infrequently determines the fate of the patient. But given conscientious workmanship, it is reasonable to infer that the success of many desperate operations must be in ratio to the time occupied in their performance, since experience has amply proved that the longer the exposure the greater becomes the risk of shock and other complications.

The publication of this series of 1,200 and odd operations, each completed within twelve minutes, a number limit suggested by clock (and which contains 1,000 operations concluded within a ten minute limit), is solely intended to impress on surgeons, who may not, as yet, have found their stride, that design, detail, and execution form an interdependent trio, which by constant association and practice develop automatic co-ordination between the brain and hands, admitting of concentration and rapid application, with a corresponding economy of time, which may, in some instances, be the vital factor in the operative result.

A glance at the appended list will suffice to demonstrate that most of these operations are simple repetitive ones, and consequently renders it obvious that personal dexterity becomes a very secondary consideration in comparison to the methodical arrangement of the procedure; I have little hesitation in stating that, irrespective of the magnitude of the operation, it is the minute study of details and the correct order of their application which constitutes good workmanship. If I were asked what detail in particular merits most attention, the reply would be: keeping the parts from start to finish under manipulative domination, as there is nothing so prodigal of blood and time and nothing so bewildering as to allow severed structures—for example, the flaps of an amputated cervix uteri, the stump of a subtotal hysterectomy, or the incised wounds of a gastro-enterostomy—to slip out of control at the crucial moment and flood the whole field with blood. Also I think that there is nothing so conducive to expeditious surgery as knowledge of the anatomy of the part, nothing so detrimental as unnecessary chatter, and there is no greater handicap than that obsession of overcare which often ends in fumbling into or laying the very traps which the indecisive brain is labouring to avoid.