A METHOD OF ENUCLEATION OF THE TONSILS.

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HAVING always been greatly interested in the removal of the palatine tonsil, I have during the last two years been perfecting a *modus operandi* which should have for its object the complete removal of the tonsil with its capsule; the technique of which should be essentially an open surgical dissection of the tonsil out of its bed, capable of being done rapidly and not exposing the patient to the prolonged and deep chloroform anaesthesia necessary in several methods already described.

By my method the tonsil is removed with the capsule intact, and the patient suffers from the minimum of shock. In hospital I use ethyl chloride always, but in private practice C E mixture.

The instruments necessary are two pairs of special forceps, a medium-sized guillotine, a Doyen's gag, and a tongue clip.

The forceps are shown in illustration. They are 8 in. long, and in shape like a pair of cleft palate forceps, but stouter in the blades. The ends are toothed. When open they can be used as tenaculum forceps to grasp the anterior pillar of the fauces, but when closed are used as blunt dissectors; the left hand pair is slightly curved on the flat for the last 1½ in.

The patient lies supine on a table of medium height, and towards the right side of it, without any pillow, and the head only slightly retracted. The anaesthetist stands at the head, and the operator on the right side facing the head. A Doyen's gag is placed between the incisor teeth closed. A good top light illumination is necessary; a head-light must otherwise be used.

When the patient is fully anaesthetized the gag is widely opened and the tongue fully drawn out of the mouth by means of a pair of tenaculum forceps held by an assistant. With the straight pair of forceps in the right hand the operator catches hold of the left anterior pillar of the fauces low down, and pulls it forwards and outwards away from the tonsil. The forceps in the left hand being closed and used as a dissector, a hole is torn with them through the mucous membrane lying between the tonsil and the portion of the anterior pillar held by the right hand forceps. The white pearly capsule at once comes into view lying just beneath the mucous membrane. This opening is deepened for about half an inch; and then, with a steady circular motion the dissecting (left hand) pair of forceps is swept up the front of the tonsil, across the upper pole, and down the posterior side of the tonsil, thus separating it from its anterior upper and posterior attachments. The mucous membrane of the pillars is found to split quite easily at the junction with the pharyngeal surface of the tonsil.

Leaving the left tonsil, the right anterior faucial pillar is now grasped low down with the left hand pair of forceps (previously used as a dissector), and the dissection made as before, with the right hand pair of forceps closed. The tonsils are now free, except on the outer surface and at the lower pole. The tongue may now be released, the forceps put aside, and the separation of the deep surface of the tonsils completed with the index finger. They will be found to strip down quite easily as far as the lingual prolongation, and will be hanging free in the pharynx, attached only by a narrow neck at the lower pole. The patient is turned on the right side to drain any blood out of the mouth; and the operation is completed by passing a medium sized guillotine over each tonsil and dividing the

small pedicle at the lower end. I find the guillotine preferable to curved scissors. At first it may be a little difficult to find the tonsils and thread them through the guillotine, this portion of the operation having to be done by the sense of touch only, but practice soon makes it quite easy.

The whole operation on both tonsils and curetting of adenoids can be done in from forty to sixty seconds. The method is rapid, complete, and only one change of instruments is necessary from start to finish.

THE BLIND AND THE CENSUS OF 1911, TOGETHER WITH STATISTICS AS TO THE CAUSE OF BLINDNESS.

BY

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UNDER the above heading the JOURNAL of November 4th last, reporting the annual meeting at Birmingham, and also *The Blind* of October, both contain an interesting paper by Mr. Bishop Harman, which at once raises a question, to which, for many years, I have been trying (in vain) from many sources to obtain an answer. This is: *When is a person to be considered blind?*—or, in other words, *What amount of defective vision should qualify an individual to be classified as blind?* and so entitle him or her to be not only included as blind in the census returns, but also eligible for one of the many blind charities entrusted to the various committees, to be expended for the "benefit of the blind." In every case the reply has been the same, "That they have no scientific definition of the term 'blind.'"

I therefore read with much pleasure Mr. Bishop Harman's paper, in which he states correctly that, "The census paper failed to obtain anything like a proper enumeration of persons who were blind for the practical purposes of life." No one with any knowledge of the blind can take objection to this, especially as some of your readers may recollect, at the London Conference of the Blind, in 1902, in answer to my question to the Registrar-General as to when a person should be considered blind, I was told that he supposed a man was blind "When he could not see"; comment on this is unnecessary.

So far as the education of children is concerned, the Act has it plainly defined that "those who are unable to read the ordinary school type" must attend a blind school. For educational purposes this may, with or without a myope school, be accepted. But cases are within my knowledge of children at blind schools reading the paper to their schoolmates, and of others learning to read the sighted type (which, naturally, is not included in a blind school curriculum) after leaving school. With such cases (which were included in the census as blind) there can be no doubt that the census to be of any statistical value should divide those with imperfect sight into two classes:

1. Blind,
2. Defective vision,

as suggested to the Registrar-General by the deputation who waited upon him; and it is disappointing that he did not think fit to act on their and his own (or his predecessor's) suggestion (made at the 1902 Blind Conference) when compiling the census of 1911.

I have always held that those with defective vision should be divided into three classes:

1. No perception of light. These only, *ipso facto*, are "totally blind."
2. Those able to read the ordinary test type, namely, $\frac{5}{60}$ —that is, can read at a distance of 20 ft. what a normally-sighted person can read at 200 ft.—are not blind.
3. Includes the intermediate class, and this is where the difficulty asserts itself. Again a subdivision must be made into—

A. Those who can differentiate—that is, count the upheld fingers—at varying distances, whom I classify as "partially blind."

B. Those who cannot differentiate, but can only see an object (for example, the hand) moving at varying distances from the face.

It is clear Class 1 is blind in every sense of the word, and Class 3 is *not* blind in the true meaning of the term.

Class 2 requires a further definition, and it was on this point that I solicited in my various letters the opinion of those who had funds, etc., placed at their disposal for the benefit of the blind. Alas! no one ventured an opinion, as above stated.

My personal definition of Class 2 has for many years been that those included under the above Section B should be considered blind, and of Section A (the partially blind) *only* those who *cannot* differentiate (that is, count fingers) at a greater distance than 3 ft. should be classified as "blind"; and I based my argument on the practical fact that a basket maker, ship-fender maker, cane chair seater, etc., who could do more than this, could distinguish his rods, strands, and canes, thereby placing his less fortunate fellow-workman at a considerable disadvantage, especially when a bonus at the end of the year was divided in proportion to the wages earned. In Hull we have found this definition most satisfactory, and one on which the "free tram rides" recently granted by our Corporation has been based, without any conflicting opinion; as a matter of fact, only six of the applicants for free tram rides could count fingers even at 3 ft., most having considerably more or less defective sight.

I had some conversation in London with my friend, Mr. Bishop Harman, on this point in May last, and whether our discussion had any weight with his views or no, I cannot say, but I note in his paper he also defines the blind "As those whose vision does not enable them to do more than distinguish fingers up to the distance of 1 metre." This, of course, is practically the same definition as my own.

Those who are classified as "partially blind" (and probably, if young, educated in a blind school) are certainly the class needing assistance at any time, and especially on leaving school, but with the above definition many are ineligible to participate in workshops and funds contributed for the blind. To meet this class, we in Hull admit them to our workshops as journeymen, and further include them in special entertainments, such as summer outings and Christmas distribution of gifts, and also occasionally give them clothing, etc., from our sick benefit branch, but they do not participate in our bonus on wages earned or the full benefits of our sick benefit, etc., branch. All, however (reading Braille, etc.), have the use of the library and our dining-room (where occasionally free dinners are provided), and I would suggest this to other towns as a means of assisting this class as well as of keeping an eye on their moral and spiritual welfare.

Further, I limit the amount of defective vision in those classified as partially blind to those who, although able to differentiate at a greater distance than 3 ft., yet are unable to see more than $\frac{1}{8}$ —that is, I exclude from this class those who can see at 20 ft. what a normally-sighted person can readily define, with or without glasses, at 200 ft.

Bearing on this subject, I have it from the Registrar-General that the 1911 statistics of blind persons are not yet available, but that the 1901 census of the blind of the United Kingdom was returned at 32,823, of a population of 41,458,721, or 1.263 per 1,000, and that of Hull as 214 blind in a population of 240,259, or 1.122 per 1,000.

We believe the Hull Blind Institution includes every really blind person in every sphere of life, and the numbers on our list in 1901 was 189, so that with my above definition of when a person ought to be classified as blind, probably 25, or about 10 per cent., of the 214 returned in the census of 1911, should really have been classified as "defective vision" or partially blind. If this is correct, it would reduce the actual number of blind in the United Kingdom in 1901 from 32,823 to 29,543 or thereabouts.

During the twenty-eight years I have been intimately connected with the Hull Blind Institution there have been enrolled on our list 590 persons unable to count fingers (that is, to differentiate) at a greater distance than 3 ft., every one of whom I have personally known and examined, so that the following figures may be taken as fairly accurate and of interest as bearing on this subject.

Of these 590 of all ages (from 4 days to 96 years), 331 were males and 259 females=590.

The cause of blindness included—

Atrophy of the optic nerve	160
Ophthalmia neonatorum	91
Glaucoma	62
Irido-choroiditis (under which term I include general disease of the tunica vasculosa) ...	60
Sympathetic ophthalmia	37
Leucoma—	
Inflammatory	32
Traumatic	2
Congenital	2—36
Shrunken globe	31
Detached retina	18
Retinitis pigmentosa	12
Congenital cataract	3
Microphthalmos	3
Purulent ophthalmia in the adult	2
Pyæmic panophthalmos	2
Congenital amaurosis	2
Kerato-malacia	1

Cause unentered 50

Total 590

During the Decades.	Number became Blind.	
	From all Causes.	From Complete Atrophy of Optic Nerve.
Age 1 to 10	115	10
" 10 to 20	42	9
" 20 to 30	47	16
" 30 to 40	62	36
" 40 to 50	85	51
" 50 to 60	57	22
" 60 to 70	73	13
70 upwards	47	3
Date unentered	62	—
Total	590	160

I believe ophthalmia neonatorum is generally considered to be the primary cause of blindness. Doubtless in years gone by this was so, but from my above figures it is clear to-day atrophy of the optic nerve ranks first, and much clearly has yet to be discovered in the preventive and therapeutic treatment of these cases. Further, atrophy occurs in the middle decades of life, especially between the ages of 40 and 50, and another point of interest is that death usually follows spinal atrophy in four or five years, while those with cerebral atrophy live to a much longer period, as the following chart shows:

Chart showing number of deaths in the various years following complete cerebral and spinal atrophy of the optic nerve. Of the 10 cases of atrophy occurring during the first decade, which include 3 imbeciles, all died under 10 years. Black line=cerebral atrophy; dotted line=spinal atrophy.

Of the 160 on our books blind from atrophy—

In 1884 there were	37
Added between 1884 and 1894	20
Added between 1894 and 1904	90
Added between 1904 and December, 1911 ...	13

Whether this decrease in numbers during the last seven years is due to recent advanced cerebral surgery I would not say, but it certainly gives the impression that it is not unlikely.

Of the 115 blind afflicted during the first decade of life—

Ophthalmia neonatorum was the cause in	91
Atrophy of the optic nerve	10
Sympathetic ophthalmia	3
Congenital cataract	3
Microphthalmos	3
Congenital amaurosis	2
Congenital leucoma	2
Kerato-malacia	1

Of the 91 ophthalmia neonatorum, the blind on the Hull Blind Institution books—

Numbered in 1884	53
Enrolled between 1884 and 1894	20
Enrolled between 1894 and 1904	16
Enrolled between 1904 to December, 1911	2
	91

This very satisfactory and steady decrease is undoubtedly due to the information circulated as to prevention.

Of the 37 blind from sympathetic ophthalmia—

From 1884 to 1894...	23 were on the books.
From 1894 to 1904...	10 were enrolled.
From 1904 to December, 1911...	4 were enrolled.

37

This decrease undoubtedly is due to the advances in ophthalmic knowledge and treatment.

Of the 82 blind from glaucoma—

From 1884 to 1894...	44 were on the books.
From 1894 to 1904...	20 were enrolled.
From 1904 to December, 1911...	18 were enrolled.

82

These figures are most unsatisfactory, as proving that the treatment of glaucoma is not yet perfect.

In conclusion, I would hope that any of your readers who are in a position to give reliable statistics, based on the above lines, will endeavour to do so, and if they will communicate with me, stating the number of the blind at their disposal, I shall be pleased to forward sufficient printed forms to fill in, for the necessary analysis, and at a future time publish the results.

THE CASUALTIES IN TIBET.

BY

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A SHORT account of some of the wounded who, after the recent fighting between Chinese and Tibetans, came under my care in the Civil Hospital, Gyantse, may prove of interest.

Most fighting took place in the Shigatse Valley, some considerable distance from Gyantse; for this reason the majority of the wounded went to their own villages instead of walking the long distance to the Gyantse Hospital for treatment. In all, seventeen wounded came for treatment, five being Chinese and twelve Tibetans. It was noticed that, while wounds by Chinese bullets did well as a rule, those inflicted by Tibetan bullets were almost invariably septic. This is to be attributed to the lower velocity of the Tibetan bullets, and to their great variety in shape. Sword wounds were in many cases very serious. The Chinese were equipped with Mauser rifles of modern pattern. The Tibetans relied chiefly on their muzzle-loading prong guns, the bullets of which are roughly spherical, usually made of lead and of about 500 bore.

Out of the seventeen cases, only ten were serious enough to merit description, four Chinese and the remainder Tibetans.

CASE I.—M., Chinese male. Bullet wound left side of neck. The wound must have been inflicted by an irregularly-shaped bullet travelling with low velocity. The tissues between the wounds of entrance and exit had sloughed away, leaving a lacerated cavity from which much pus was oozing. The lower part of this patient's face was considerably swollen. The wound, though very septic, ultimately did well.

CASE II.—W., Chinese male. Bullet wound right knee. The bullet entered at the inner side of knee, slightly tearing the semimembranosus tendon, and emerged on the inner side of the patella, forming a sinus about 5 in. long. No important structures had been injured, but healing was very slow.

CASE III.—P. T., Tibetan male. Bullet wound left knee. This was a very bad case. Practically all the tissues on the inner side of the knee had been shot away. The wound was very foul and in part gangrenous, while a considerable amount of pus escaped from the joint and the thigh muscles. His only chance was amputation, but this he refused, so treatment was confined to general cleaning of the wound and clipping away of the affected tissues. He was greatly run down, but, refusing to stay in hospital, went home. This patient can have very little chance of recovery.

CASE IV.—L., Tibetan female. Sword wounds head and hand. The head wound in this case commenced at the upper border of the right eyelid, which was divided, and extended downwards and to the left to the inner canthus of the left eye, dividing *en route* the nasal bone just below its junction with the frontal. In addition, she had other smaller scalp wounds and a badly lacerated hand. All the wounds were septic and it was undoubtedly a very bad case, but she made a good recovery. One finger had to be amputated.

CASE V.—M., Chinese male. Sword wound head and hand. The largest wound extended from the root of the nose upwards for about 6 in., exposing the skull. There was also a deep punctured wound above the right ear. Both these wounds suppurated, as also did his right hand, which showed a ragged wound on the dorsum of the index and middle fingers. Owing to the fact that the edges of the largest wound were undermined the wound was difficult to keep properly clean; healing was slow.

CASE VI.—P., Tibetan female. In this case there were two long, deep wounds of the scalp, one running upwards and outwards from above the left eye, the other on the top of the skull. The edges here were also undermined—almost "sliced," one might say. She made a good recovery.

CASE VII.—S., Tibetan male. Bullet wound back and arm. The bullet entered the back at the level of the angle of the fourth and fifth ribs. The wound of exit was situated in the anterior axillary line at the level of the eighth rib. The bullet then passed through the inner aspect of the upper arm 4 in. above the condyles, the wound of exit being on the anterior aspect of the upper of the same level as the wound of entrance. The biceps muscle was much torn, and there was considerable hæmorrhage. As a large amount of pus was escaping from the wounds in the back I slit up the track of the bullet and found that the fourth and fifth ribs at their angles were comminuted. On the fragments being removed the wounds healed rapidly. The patient is still under treatment, as he has very little power in his arm.

CASE VIII.—P. G., Tibetan male. Bullet wound thigh. The bullet passed from above slightly downwards, entering the outer aspect of the thigh at the junction of its lower and middle thirds and emerging on the front of the thigh. Although the wound was a deep one no important structures were damaged, and once the wound became clean it healed fairly quickly.

CASE IX.—J., Tibetan male. Bullet wound of left knee, sword wound of the head. The wound on the front of the left knee was a large lacerated one, destroying the surrounding tendons and causing great swelling of the joint. It was a very similar wound to that mentioned in Case III. Pus was escaping from the joint. The sword wound of the head was very deep; the skull was fractured, and through the fissure a little pus could be seen. The patient died of septic meningitis.

CASE X.—C., Chinese male. Bullet wound right arm. This was the most interesting case of all. The patient was wounded beyond Shigatse, and although in great pain had walked to Gyantse for treatment, a four days' journey. The bullet grazed the right side of the chest and entered the inner aspect of the upper arm, 2 in. below the level of the great tuberosity. No wound of exit could be seen. As pus was escaping from the large ragged wound, it was evident that something was keeping up the discharge. Under chloroform an incision was made downwards from the lower end of the wound, and, after considerable hunting, a bullet was found lying very deep down, somewhat behind the humerus. The upper end of the bone was comminuted, the bullet, a round leaden one about the size of a small marble, showing a ragged projection where it had struck the bone. The patient is still under treatment, and is doing well.

DR. WILLIAM JOSEPH ESSERY, of Southsea, has been appointed a Commander of the Royal Victorian Order.

It would appear from the annual report of the Yarrow Home for Convalescent Children at Broadstairs that its utility during the winter months as well as other seasons of the year is being increasingly appreciated, for on December 31st there were as many as 83 children on the books. It would appear also that the committee is now working more closely in accordance with the original intention of the founder, and therefore admitting only children whose parents can be considered as belonging to the professional or educated classes but whose means are very limited. The London address of the home is 6, Holborn Viaduct, E.C. Its full title is the Yarrow Home for Convalescent Children of the Better Class, and it is fully endowed.