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.