

Haemorrhage from Peritonsillar Abscess

SIR.—Surely Mr. T. G. Wilson (September 8th, p. 491) misreads his "Cunningham" when he says that the tonsil is partly supplied by the descending palatine branch of the internal [*sic*] carotid artery. The internal carotid artery has no such branch, and the vessel named arises from the external carotid in the sphenomaxillary fossa.

In any case the contribution of the descending palatine artery to the tonsil is negligible when compared with that of the ascending pharyngeal artery, the facial artery by its ascending palatine and tonsillar branches, and the lingual artery by its dorsalis linguae branch.

Mr. Wilson's reason for ligaturing the common carotid artery would hardly appear valid unless associated adenitis made exposure of the external carotid too difficult, which does not appear to have been the case. The external carotid should be chosen for ligature, due regard being paid to the partly concealed and often very low origin of the ascending pharyngeal branch.—I am, etc.,

Canterbury, Sept. 10th.

THOMAS A. CLARKE.

SIR.—During recent renovations at my house, where Dr. J. H. Watson once had consulting rooms, the enclosed fragment was discovered among the deeper strata of *Fishery Gazettes* accumulated in the waiting-room. Apart from the intrinsic interest, it appears to have a bearing on a recent correspondence in your pages upon Haemorrhage from Peritonsillar Abscess.

"... a small monograph on *Inductive Reasoning as Applied to Anatomy*. The section upon the tonsil, for instance, points out that it is very like a lymph gland in structure; and, like a lymph gland, bleeds very little when cut. We should therefore expect to find a similar scanty blood supply from a single artery entering at a similar hilum where the veins emerge. It is exposed to the force of gravity and the tug of swallowing, both acting in the same direction.

There should therefore be, as elsewhere in the body, both a muscular suspension and a fibrous ligament to counter these forces. Abscesses are apt to form round its upper half, so that on the analogy of perirenal and orbital suppurations there should be an areolar space surrounding it. The absence of these abscesses round its lower half would presumably show that it is there that our hypothetical muscular suspension is attached to the capsule. Dangerous bleeding may occur on one side and not on the other after the removal of identical tonsils by identical methods. Therefore this bleeding comes not from a vessel that supplies the organ, but from an independent one that may or may not be wounded, as the common facial vein may or may not escape injury in the removal of the glands of the neck. The bleeding is slow and persistent; such bleeding comes only from a vein. The narrow calibre and contractility of small arteries prevent any great loss of blood from them, just as their thick walls render them less liable than veins to perforation in surrounding sepsis."

"But, Holmes," I broke in, "bleeding after tonsillectomy is spoken of by all the authorities in terms of arteries, not of veins." Without even a glance in reply he continued, "We therefore have cause to suspect the common occurrence of a medium-sized vein, unaccompanied by an artery, running close to the capsule of the tonsil, in the areolar tissue between its upper half and the palate muscles. This vein would cause the persistent bleeding noted either after tonsillectomy or the bursting of a peritonsillar abscess, and controlled by ligature of the external carotid. It would also account for the disproportionate number of deaths under local anaesthesia for tonsillectomy; the unwary surgeon being liable to inject his drug almost directly into the heart."

At this point I began to wonder whether Holmes's mixing of cocaine with his morphia, against which I had more than once warned him, had at last affected his once brilliant brain. And his next remark, as to confute his wild ramblings I reached down the revered and well-thumbed volume of Cunningham from my shelves, only served to confirm this

sad suspicion. "If one were to describe exactly what one finds in the human body, uncaring whether or not it agrees with the books . . ."

Here the fragment ends.—I am, etc.,

London, W.1, Sept. 8th.

DENIS BROWNE.

Orthopaedic Treatment of Infantile Paralysis

SIR.—In these observations I particularly desire to draw attention to those developed cases of extensive muscle weakness in the lower limbs which six months after the onset of this disease show few clinical signs of recovery.

For example, a child of 6 years of age is found at the original examination to have apparently no power of movement in the left leg, and in the right leg movement of toes only. After six months of complete rest (recumbency on a satisfactory splint), competent trained nursing, and orthopaedic supervision the following condition is found: there are still no signs of recovery of voluntary power in the left leg, but in the right are found early evidences in all the muscle groups. At this stage a complete return of normal muscle function in the right leg is unlikely, while the prognosis as to any improvement in the left leg has to be most guarded. Due consideration having been given to this difficult subject of prognosis the time has arrived for anxious thought regarding the future of a patient who is obviously going to be grossly handicapped in the struggle for existence. It has become necessary to plan the life and the treatment of the individual for ten or twenty years in advance. The earlier this problem is faced in all its aspects—medical, financial, and educational—the better for everyone concerned.

It has been my privilege to supervise personally the orthopaedic treatment of cases of this description from early childhood up to adult life, and I strongly advocate that "the long view" must be taken with every patient. During this extended treatment the essential aims to be kept in view are the following. First, the prevention of any deformity, especially one of a crippling nature; secondly, the ultimate attainment of the power of walking in a manner approaching as closely as possible to normal; and, thirdly, education in a manner best suited to ensure the capacity for earning a living.

The crux of the problem is contained in the following statement. All the essentials enumerated above are obtainable for the majority of these cases of lower limb paralysis if weight bearing is deferred until it is reasonably certain that no further gain in muscle power is possible, and that no gross muscle fatigue is likely to result. The time limit for recumbency will be a variable factor in each individual case and with individual professional experience, but I have no hesitation in advocating a minimum period of two years in every case of lower limb paralysis. In severe cases, as in the example quoted above, this period may be extended to three, four, or even five years. The only standard must be the capacity of the injured limbs to support the weight of the body. No other problem in the whole course of treatment approaches this in importance, and an error of judgement in this particular may mar the whole future life.

Too early weight bearing will cause fatigue, produce muscle weakness and deterioration, and possibly precipitate a state of crippledness which no after-treatment can wholly remedy. It is a very hard struggle to convince parents and others of the necessity "to hasten slowly" before taking this vital step. They see considerable improvement in the child's condition while strict recumbency is being maintained, and constantly desire to know when the child will be allowed to stand.

This dangerous impetuosity must be resisted and the plan previously mapped out stubbornly adhered to. A constant propaganda explaining the evils of too early weight bearing has to be carried on. Lest my proposition should appear fantastic, I may point out that in the case of tuberculosis of the hip-joint it has been brilliantly successful. All concerned with the treatment of tuberculosis of this joint have been educated to appreciate that there is no time limit for treatment. The moment for weight bearing in this disease is left absolutely to the judgement of the surgeon. Muscle and bones, which are grossly weakened following upon an attack of infantile paralysis, are at least equally as important as