

THE TREATMENT OF POST-NASAL ADENOIDS.

SIR.—Under the above title, in the *BRITISH MEDICAL JOURNAL* of January 28th, Dr. Ward Cousins recommends the sterilized finger nail as the best instrument for removing adenoid growths in children. Such a reactionary step calls for some comment, particularly as the incautious opinion is given that “the removal of these growths can be undertaken without any risk, provided there is no active disorder or any impairment of the health.”

I have, many years ago, attempted the removal of adenoids with the finger nail. In slight cases or in soft growths it may prove sufficient; part of the growth is removed, involution takes place in what is left, and symptoms are relieved. But in London, where we have such good opportunities of becoming, as Judge Bowen said, so conscious of one another's imperfections, it was long ago recognized that most of the “return cases” of adenoids came from the hands of practitioners who employed the “finger-nail” operation. Nearly all these surgeons have now given this up for the more rapid, thorough, and certain curette, particularly the one furnished with a cage, which gives both the operator and the patient's friends the satisfaction of seeing the removed mass.

The discredited finger-nail operation revived by Dr. Ward Cousins does not avoid the use of a general anaesthetic; and, as he recommends the hanging-head position, all the usual risks of the operation are not only still existent, but even increased by a slower procedure, greater haemorrhage, and the presence of loose pieces of growth in the pharynx.

It is difficult to understand what are the indications for the roughened metal probes which are passed through the nose and “freely applied around the posterior orifices and rubbed over the inferior nasal passages.” Adenoid growths may overhang the roof of the choanae, but do not grow around them. The nasal passages are frequently infected with a secondary catarrh from suppurating adenoids; this clears up promptly in children on removal of the primary source, aided by hygienic and simple cleansing measures. In certain cases, chiefly in older patients, secondary hypertrophic changes do occur in the nasal mucosa. But this calls for appropriate local after-treatment, applied under the control of the eye to the points required.

Any general acceptance of the finger-nail operation would, I fear, discredit the removal of adenoid growths, a proceeding which at present is one of the most satisfactory in its results in suitable cases, and one of the most frequent in surgery.

As for the nasal probes which are to be blindly “rubbed over the inferior nasal passages,” it is difficult to treat such a recommendation seriously! In the narrow and delicate nasal chambers of children such a measure is not free from danger, is quite uncalled for in the majority of cases of adenoids, and at the present day has been superseded by more precise and safer measures.—I am, etc.,

London, W., Jan. 30th.

STCLAIR THOMSON, M.D.

SIR.—I think that many medical men in general practice will have read Dr. Cousins's article on the treatment of adenoids with great interest, for it is a subject the details of which, both as regards the operation and after-treatment, are not given fully in the ordinary textbooks.

Not long ago there was an extensive correspondence in the *BRITISH MEDICAL JOURNAL* on the causation of adenoids, and many theories were put forward to account for their serious consequences and the wonderful results which follow their removal. After all, it is only what is seen in Nature on every hand, a weed-like growth blocking up a channel which has become disused. An ordinary ditch will remain free from weeds so long as the water flows along it. Divert the water and the channel will quickly become obstructed; restore the flow of water before the obstruction is complete and the channel will become again clear; but each time the water ceases to flow the weeds get the upper hand. So with adenoids, breathing exercises are all that are required for the slighter cases; but once the obstruction is complete the child must be given a fresh start by having the adenoids removed. A child comes into the world able to breathe through its nose, it develops a nasal catarrh, and has to—or rather, finds out that it can—breathe through its mouth. The habit is started, and in many cases is never given up; the post-nasal space becomes blocked with adenoids, and the nasal passages become narrow and contracted. But these conditions are not the cause of the adenoids, they are the result of them. The enlargement of the tonsils is practically always secondary to the nasal obstruction. Consisting as they do of lymphoid

tissue, with a number of crypts and follicles, the tonsils are ready to act as receptacles for any dust, micro-organisms, fungi, etc., which may be inhaled; these excite a chronic inflammation and consequent enlargement.

As regards the method of operating, I prefer the Mason gag to the wooden rod of Dr. Cousins. This gag uses very little space, it need not be shifted from one side to the other, there is very little risk of having the fingers nipped, and it is not likely to disturb or break a child's delicate teeth. When the patient is under the anaesthetic, and before there is any haemorrhage, the nasal passages should be dilated. An ordinary gum-elastic catheter—No. 12 to 14—answers admirably, and, being uniformly cylindrical, causes dilatation along its whole course. It should be well lubricated with vaseline and passed through first one nostril and then the other, on to the finger of the left hand held in the nasopharynx. This dilatation of the nasal passages is very important, for however thoroughly the adenoids are removed, if the effort to draw the air through the nose is not diminished no advantage will be taken of the freedom of the post-nasal space.

Dr. Cousins clears away the adenoids and then excises the tonsils, but it seems to me that the order usually followed is better. The tonsil guillotine is much simpler to use when there is no haemorrhage, whereas the finger in the post-nasal space is not interfered with by haemorrhage at all. There is always, too, more bleeding from the adenoids than the tonsils.

The important points in excising the tonsils are worth going into. Having guided the ring of the guillotine by the finger on to the tonsil, the instrument should be held, not parallel with the cheek, as shown in some illustrations, but right across the mouth. With the patient on the table, a right-handed person should stand on the right side for the left tonsil and behind the patient's head and a little to the left for the right. This latter position is very similar to that adopted by the dentist for extracting lower teeth with hawkbill forceps, and is very much more convenient than changing hands and removing both tonsils from the front.

The after-treatment of a case can be said to be completed when the child sleeps at night with the mouth shut without attention. This requires constant care on the part of the nurse and parents. Tying up the chin in conjunction with a tilting down of the head will generally close the mouth, and keeping the child off its back is a valuable help. With intelligent children much may be done by impressing them at the last moment when in bed with the importance of keeping the mouth shut, for it is well known that ideas to which attention is directed just before going to sleep have great influence even during sleep itself. In the day time simple breathing exercises should be carried out regularly three or four times a day for at least two months.—I am, etc.,

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Barnes, S.W., Jan. 30th.

COMPULSORY GREEK.

SIR.—I regret to learn, from your leading article on January 28th, that, while apparently recognizing the advantages of a knowledge of Greek, you suggest that the medical graduates of Cambridge shall help in its abolition as a compulsory subject. As regards the opinion of the Association of Assistant Masters, I certainly regard the fact that 98 per cent. of them do not teach Greek as discounting their opinion. And I believe that Cambridge will do very well without opening its portals to the mass of students you mention, whose idea is that nothing is of educational value unless it can be directly applied to the trade or business they propose ultimately to adopt. To my mind it is those who intend to study science or medicine, who require to have their education widened to the greatest extent possible, in order to avoid the evils of specializing. I am afraid that I cannot agree with you that Greek as generally taught is of no educative value whatever, although you regard the opposite opinion as cant. You say that the majority of boys do not learn Greek at all. I might ask, Do the majority of boys learn anything at all? It seems to me that in arguing about education most people insist on assuming that all boys are highly-intelligent creatures thirsting for knowledge. This is almost absolutely contrary to fact, and education should be regarded as a mental training, and not as the learning of something that is to be “useful” in after-life. Does any one in his senses suppose that the average boy will take any more interest in learning French than he now does in learning Greek? Why substitute French