results should do harm rather than good. First, it is to be hoped that others will not be diffident about reporting failures because of this triumphant series of successes. It seems that I differ from many of my surgical colleagues in that I have had a death from appendicitis within the penicillin era. The case taught me more than my successes had done, and I feel that one fatality may be more informative than many a successful run. The patient was a man of 58 years who was admitted with general peritonitis from what turned out to be a perforated appendix, which was removed. He had all the advantages of sulphonamides, gastric suction, intravenous fluids—and penicillin. Admittedly the penicillin was not given until the fourth post-operative day, but the other adjuvants were used from the start. The patient died on the twelfth day of his peritonitis. There was no other contributing disease; he had been a healthy, strong man. The case caused me to scrutinize all the details of management, and one change was made. Since that time any complicated case has been treated by me from the outset with sulphonamides and streptomycin. On theoretical grounds penicillin is not an antibiotic of choice for coliform peritonitis. In so far as it may produce false confidence, I think it should not be given the emphasis that has been awarded to it in the article. If there is an indication for antibiotics one ought to give the best one available, and penicillin is surely a broken reed for this particular purpose. Your annotator (December 16, p. 1376) might agree with this, though his statement is not so emphatic.

There is one small point, too, about ordering sulphonamides. If the patient is on gastric suction they must be ordered to be given parenterally: otherwise we shall find ourselves giving the credit for improvement in results during the "sulphonamide-penicillin era" to the anaesthetists—but that might not be such a bad idea.—I am, etc.,

Northolt, Middlesex. E. A. TURNER.

SIR,—The article by Sir Cecil Wakeley and Mr. Peter Childs (December 16, 1950, p. 1347) makes me look back over forty years on my own view of the treatment of appendicitis.

I well remember, in 1908, being told by the late Sir David Wilkie of his vacation at the clinics of Kummel and Curacoa Kummel operated on all cases of appendicitis and Curacoa was a physician who treated all his cases with castor oil, but the mortality rate in each case was the same. The next impression I obtained of the treatment of appendicitis was when I became a house-surgeon to the late Sir John Lynn Thomas in 1911. He was a disciple of Murphy, of Chicago, and treated all his cases by the Ochsner-Murphy drip method. All went well until a nurse, aged 19, died, and afterwards all cases were operated on, especially since Moynihan expressed his view that a purgative often caused perforation of the appendix.

After this I had experience in general practice, and in one week saw three deaths from appendicitis, all of which were operated on in their own homes by a consulting surgeon: operation had been too long delayed. Following this a small cottage hospital was built, containing 26 surgical beds. I was appointed surgeon and was able to operate on all cases.

In the period 1925-46 I performed 800 operations with a mortality rate of 0.5%, and from 1946 to date I have performed 600 operations without a death. I operate now on all cases once a diagnosis is made. My method of treatment is the same as that adopted by Wakeley and Childs, except that I give anti-gas-gangrene serum and penicillin intramuscularly in all acute cases. In my opinion anti-gas-gangrene serum is a real life-saver. I have no waiting-list, as I consider it is too dangerous to leave any case without operation, since I believe it is impossible to know when a case will not flare up. Anaesthesia with thiopentone, gas and oxygen, and curare makes the operation simple and a pleasure to perform.

I have noticed that acute appendicitis is often associated with acute tonsillitis, and I have no hesitation in removing the appendix in spite of the tonsillitis. Penicillin treatment permits this. I had one case of Crohn's disease in which I removed the appendix. The case did well in spite of the fact that there was severe involvement of the ileum. I had two cases of Meckel's diverticulitis, both of which recovered and in which I removed the diverticulum.

The onset of gastric and duodenal ulcers as a result of recurrent attacks of appendicitis is not fully appreciated. I myself developed a duodenal ulcer and had a gastro-enterostomy performed at the age of 50. I recollect attacks of abdominal pain off and on since childhood. My appendix was removed and found to be fibrosed and adherent. This was the cause of my pains and probably of the ulcer.

With the knowledge that the public have of appendicitis it is imperative that operation should not be delayed, and after forty years' experience as a general practitioner I do not hesitate to recommend operation in every case of appendicitis. My work has been considerably lightened since I have adopted this treatment. Night and emergency calls are lessened.—I am, etc.,

Treorchy, Glamorgan. FERGUS ARMSTRONG.

Tonsillectomy

SIR,—It is to be hoped that the judicial approach of Dr. A. H. Gale in his able article (January 20, p. 133) will stimulate a like attitude generally. There is, for instance, an obvious disparity between the general anxiety to avoid tonsillectomy in a poliomyelitis epidemic (four deaths in 1949 under these circumstances) and the cheerful acceptance of the ordinary risks of the operation (80 deaths a year, according to Dr. Gale). May I add one comment concerning that large group of potential subjects for tonsillectomy, young schoolchildren of 5 to 7 years who suffer from recurrent upper respiratory infections. If to these one applies conservative measures, one quickly learns what the natural history of the syndrome is—that it is usually self-limited, with a marked tendency to spontaneous cure at about 7 or 8 years. Therefore decision about operation on this group of young schoolchildren should be postponed as long as possible. Since at most centres there is in any case a delay of many months before a booked tonsillectomy is performed, it would be well worth while to assess each child's need for operation again as his turn approaches. If this were done I believe many of these children would end by keeping their tonsils.—I am, etc.,

Cambridge. DOUGLAS GAIRDNER.

SIR,—Dr. A. H. Gale's article (January 20, p. 133) on pros and cons of tonsillectomy brings this perennial problem once more into the limelight. He is to be congratulated on its concise wording and its brevity. I believe statistics on this subject, as in many others, are not to be trusted; so many data are not available, and many who rely on statistics have some axe to grind. Dr. Gale quotes Kaiser's definite indications for tonsillectomy. Nos. 1-5 are, I would suggest, indications for adenoidectomy rather than tonsillectomy, and No. 8 should be excluded, at least until appropriate non-operative treatment for sinusitis has been given. I agree that Nos. 9-12 are very indefinite indications.

Dr. Gale might have said more on the subject of enlargement of tonsils. It is my experience that many practitioners regard enlargement as *the* indication for tonsillectomy. This is definitely not so, and in fact it is more often the small adherent buried tonsil which harbours the organisms responsible for chronic adenitis or recurrent tonsillitis. In his conclusion, Dr. Gale says the decision should be made by the general practitioner and the laryngologist, working together. I heartily agree with this. Unfortunately, very many of the cases referred for opinion come not from the G.P. who knows the medical history of the patient, but from the school medical officer, who of necessity sees the child only when well enough to attend school and, judging from the wording of most requests, regards enlargement as the chief indication.

It is to be hoped that the critical surveys encouraged by the poliomyelitis controversy will enforce more rigid selection of cases, for not only is the bed allocation small, but there is a real danger of laryngologists becoming pure tonsillectomists now that the regional boards are directing more and more of these operations to specialists away from