Cervical Gland Tuberculosis

Sir,—The article on tuberculous cervical adenitis by Dr. B. C. Thompson in your issue of September 19th seems to have opened once more the floodgates of controversy upon this old debating ground.. Dr. Thompson, speaking as a physician, upholds the merits of general hygienic and conservative methods, and will have no truck with surgery, while Drs. Orley and Nicholas follow a week later vaunting the merits of rays various—gamma, *x*, or ultra-violet—and are even less acceptant of the surgeons. Far be it from me to make such wide claims for my art as they for their rays, but I feel that surgery must put up some defence.

The main arguments adduced in favour of the thesis that surgery is unjustifiable in this condition (Dr. Thompson must forgive me if I do not quote his words or figures, as I have not his article available at the moment, and this letter must catch the mail to-night) are that the results are uncertain, recurrences frequent, surgical scars very unsightly, and paralyses not unknown ; that the percentage of cures by conservative methods is as great as, or greater than, that by excision ; and that even if the period of treatment is longer (Dr. Thompson speaks of, I think, weekly attendances at a clinic over a period of months or even years), the time and money expended on these is more than compensated by the ultimate results. Now I would not for one moment maintain that every case of tuberculous cervical glands should be treated surgically, but I do most emphatically maintain that there are a certain number of cases for which operation is the method of choice. Such cases are those in which the glands have actually broken down, preferably before but particularly when a discharging sinus is present, for spontaneous cure by calcification of a cervical gland is exceedingly rare—I am not at all certain that it ever occurs.

As to the surgical technique, it is imperative that an adequate operation be done. To scrape blindly down a fistula with a sharp spoon is not only inefficient surgery, it is dangerous surgery. To make a small incision and evacuate a superficial abscess is little better. The great vessels of the neck must be exposed and dissected clean of enlarged glands from the base of the skull to the clavicle, the posterior triangle must be dealt with as carefully as the anterior, and the spinal accessory nerve must be defined as the first step in the dissection. Given these desiderata there will be no recurrences, no paralyses, and the time of hospitalization should not exceed seven days. Moreover, if the incision is made in a fold of the skin, if the skin edges are protected from infection, if fistulae are excised, and if the wound is sewn up carefully in layers, a perfect scar can be obtained which is practically invisible after six months. Broad, puckered, adherent scars are not the result of efficient surgery, but of inexpert surgery or of sinuses secondarily infected and ultimately persuaded to heal. There are a number of children about in Somerset who have been operated upon by me during the past ten years, and who can prove my contention. But—and I say it in all humility—the operation is not one to be undertaken by the occasional surgeon, or by any other unless he has the anatomy of the neck at his fingers' ends, is prepared to go on until he has removed *every* enlarged gland, and will take an infinity of pains to produce a good scar. It is, I believe, one of the most difficult operations in the whole field of surgery to do really well, but the results in suitable cases more than compensate for the trouble taken to acquire the ability.—I am, etc.,

New York, Oct. 6th. E. Miles Atkinson, F.R.C.S.

Sir,—It is not surprising that surgical treatment for cervical gland tuberculosis has still some supporters, because there is no doubt that in patients where the glands are discrete and the resistance good excision properly carried out will frequently effect a cure. It is, however, my considered opinion, after over twenty years' service at tuberculosis clinics in a large industrial area, that these cases only represent a small proportion of the total number. From time to time I have sent several patients to general hospitals for surgical treatment of this condition, and many who have received such treatment at the instigation of their own doctor have attended my clinics after their operation. On the whole the results that I have seen have not been satisfactory ; patients have often returned with large, imperfectly healed scars and underlying swelling, showing that the attempt to remove the tuberculous material had been unsuccessful. In other cases the occurrence of keloid scars has been noted.

It is perhaps unnecessary here to discuss the question why operative treatment, when carried out in a busy general hospital, is so often unsatisfactory. Fortunately, the introduction of actinotherapy, and particularly the use of the carbon arc lamp, has provided a valuable and more efficient mode of treatment than operation for the majority of cases. For several years I have been treating most of my cases of cervical gland tuberculosis with artificial light treatment, combined with aspiration of softening glands, and incision where necessary. The results have been extremely good, and have been published (*Lancet*, May 30th, 1931, and *Tubercle*, February 1935). In these papers it was shown that during the period 1927 to 1933 270 cases of cervical gland tuberculosis received a course of artificial light treatment, and of those who completed a satisfactory course of treatment 188, or 98 per cent., were discharged as quiescent. At the end of 1933 it was decided to make an investigation into the after-results of those discharged as quiescent during the period 1927 to 1930, as these cases had then been under supervision for a minimum period of three years and a maximum period of six years. The figures showed that of seventy patients traceable on December 31st, 1933, sixty-seven, or 95.7 per cent., were still quiescent. These results occurred for the most part in patients with extensive adenitis, and the scarring was much less than is usually found after operation.—I am, etc.,

George Jessel,
Consultant Tuberculosis Officer,
Leigh, Lancs, Oct. 10th. Lancashire County Council.

Sir,—In the interesting discussion on the treatment of tuberculous cervical adenitis I notice Dr. Orley alone recommends ultra-violet ray therapy, and he combines it with *x* rays. I would whole-heartedly advise that all cases in the first instance be subjected to sunlight treatment, and as early as possible. It is simple, speedy, and at the same time markedly improves the general tone and resisting power of this type of patient.

Some ten years ago one of my daughters developed a chain of cervical glands, some of them as large as small tomatoes. I showed her to my friend Mr. Seymour Jones of Birmingham, the throat and ear specialist, who happened to be calling. He at once said "Operation," and very kindly offered to remove them for me. (I may say here that earlier she had been a pulmonary tuberculosis "suspect," and a radiograph, whilst showing nothing definite, suggested enlarged mediastinal glands.) I told Mr. Seymour Jones I was going to cure them with ultra-violet rays, and he said "Good luck to you." After seven, or thereabouts, exposures of my tungsten arc lamp, of increasing intensity (mercury vapour was not then as much in vogue as now), the glands com-

pletely disappeared; there has been no recurrenee, and she is to-day a normal healthy woman. To complete the story, Mr. Seymour Jones, who chanced to meet my daughter at a dance some four months after the "cure," asked her "who had done the operation."

May I go further and advocate the trial of ultra-violet therapy in all persistent cervical and thoracic glandular enlargements? I can, in my practice, look back on remarkable results that I have obtained in chronic purulent bronchitis in old people by longer courses of artificial sunlight. I allude to the long-standing cases with intercurrent attacks of respiratory distress, raised temperature, and severe general malaise, which suggest an added *mediastinal gland infection*. These cases, often considered incurable, I have completely restored to health by careful graduated ultra-violet medication of the whole chest—front, back, and sides. I have not had occasion to give more than twenty-four sittings, though in one severe case of an old lady whose chest completely cleared insisted on a course of ultra-violet ray treatment each year as "a touch down for safety."—I am, etc.,

C. Martin Mitchell, M.R.C.S., L.R.C.P.

Carterton, Oxon, Oct. 11th.

Plastic Operations for Hydronephrosis

Sir,—Mr. Hamilton Bailey is in error when he states in his paper on plastic operations for hydronephrosis (October 3rd, p. 669) that "as far as one can judge" this line of treatment has been abandoned by surgeons in this country, as well as in most others. A few years ago Professor von Lichtenberg of Berlin gave a practical demonstration of his plastic operation at one of the special hospitals in London. His technique was a delight to watch.

It has been my custom for many years to practise conservative surgery in hydronephrosis, and there are probably a number of urologists in this country who have been doing the same thing. The technique to be adopted is dependent upon the extent of the disease, and the one described by Mr. Hamilton Bailey is not suitable for all cases.—I am, etc.,

Clifford Morson.

London, W.1, Oct. 8th.

Nutrition and Orthopaedics

Sir,—I notice that in an address on nutrition, published in the *Journal* of September 26th, and read by Sir Robert McCarrison at Oxford, the report is given of a supposed cure of a case of spondylolisthesis by nutritional treatment.

As an orthopaedic surgeon I am fully appreciative of the great importance of the science of nutrition in my work. For the sake of scientific accuracy, however, I do think that it is necessary to draw attention to the fact that the case mentioned by Sir Robert McCarrison, and which was reported by me in the *Proceedings of the Royal Society of Medicine*, 1935, page 1370, still has spondylolisthesis according to the radiological evidence available. The latest skiagrams demonstrate the infraction of the laminae and the forward displacement of the body of the fifth lumbar vertebra characteristic of the condition. In reporting a cure I think it is necessary to make quite clear what has been cured. In this case I have no doubt that the malnutrition present has disappeared. The associated bony lesion, however, was still there when last studied radiologically. It is quite possibly not giving rise to symptoms at the moment.

A case of this sort illustrates well the need for distinguishing words for two phenomena at present covered by the one word "cure." Symptoms may disappear with or without treatment while an underlying structural lesion remains *in statu quo*. Conversely, and not infrequently I fear, a structural lesion may be "cured" and the symptoms remain.—I am, etc.,

Norman Capener.

Exeter, Oct. 6th.

Sir,—The statement made by me as to the cure of a case of spondylolisthesis (*Journal*, September 26th) by "a year's proper feeding combined with properly directed exercises," to which Mr. Capener refers in his letter of October 6th, was based on the following evidence: (1) the report of a distinguished radiologist and (2) the boy's physical fitness. The radiologist's report was as follows: "The apparent slight degree of spondylolisthesis shown in the skiagrams (28/4/1934 and 16/5/1934) seems to have practically disappeared by 9/10/1934, and to-day (28/3/1935) the spine appears normal." The boy's present physical fitness is evidenced, first, by the fact that he won the school swimming competition for boys of his class against a good field; and, secondly, by the report of a consulting physician, who recently failed to find any physical fault in him. The physician's comment was as follows: "I think he was singularly fortunate in avoiding an operation."—I am, etc.,

R. McCarrison.

Oxford, Oct. 8th.

Hallux Rigidus and Valgus

Sir,—Far from putting forward a solution to the problem of operation for hallux rigidus and valgus, Mr. G. R. Girdlestone has only complicated matters. Before his letter in the *Journal* of October 3rd (p. 693) the profession was more or less unanimous that one of three simple operative procedures—namely, the removal of the exotosis, the Kellar or the Mayo operation—would produce a most satisfactory result provided that the surgeon used reasonable judgement. We are now advised to perform an operation in which tissues which have been contracted for years are forcibly stretched and kept in tension by means of a bone peg—an appliance which I thought most surgeons had consigned to the lumber room along with bone plates and other forms of mechanized orthopaedics. All this has been recommended so that the adductors of the great toe can be preserved; even if they were powerful enough to act with any force on so firm a joint as the first metatarso-cuneiform joint their preservation in this fashion is totally unnecessary.

At the British Medical Association Meeting at Oxford in July of this year I had the pleasure of hearing Mr. Girdlestone describe this operation, which he naïvely called "the 1935 model"—a curious name for any operation. I wonder whether, like his neighbour and benefactor, he will change his model every two years. In conclusion, I would draw his attention to Mr. McMurray's article in the August 1st issue of the *British Medical Journal*, in a close perusal of which he would find an answer to most of his troubles.—I am, etc.,

W. J. Eastwood.

Liverpool, Oct. 9th.

"Bejel": Non-venereal Syphilis

Sir,—In your issue of October 3rd you have given an annotation describing the important work of Dr. E. H. Hudson on the Euphrates in French Syria. I would point out that the same disease under the same name is prevalent among the semi-nomadic Arabs on the Tigris between Mosul and the mouth of the Lesser Zab, and among the Jebour Arabs on the lower Lesser Zab itself. This region lies less than two hundred miles east of the affected Euphrates area.

I had experience of the condition while in the Iraq Health Service, on the Lesser Zab when civil surgeon at Kirkuk, and on the Tigris when civil surgeon at Mosul.