

Correspondence

Letters to the Editor should not exceed 500 words.

Tonsillectomy

SIR,—The investigation of operative blood loss during the operation of adenotonsillectomy (4 December, p. 1349) raises some interesting points concerning the anaesthesia for these cases. It is true that halothane does tend to cause respiratory depression and hypotension in young children, especially in the presence of haemorrhage; but these disadvantages can often be minimized, (a) by going over to ether after the preliminary induction with halothane, and (b) by avoiding premedication with barbiturates or other sedatives, which also cause respiratory depression and hypotension during subsequent anaesthesia. In a children's hospital with a good nursing staff pre-operative sedation is rarely necessary (except possibly for the mother), while the universal shortage of nurses in smaller hospitals renders it imperative that the child should recover consciousness as soon as possible after the operation.

The essential principle in all cases is to ensure that not only is the child adequately anaesthetized before the operation is allowed to start, but that the anaesthetist also has a little in hand for unforeseen contingencies, such as an intractable bleeding point or a remnant of tonsil left behind. Having graduated during the past 30 years through the traditional "T. and A." techniques with ethyl chloride, or chloroform through the Junker inhaler, I now induce anaesthesia for children with nitrous oxide/oxygen and halothane in the usual manner, and then with ether until the patient is firmly established in plane two of the third stage of anaesthesia. The Boyle-Davis gag is then placed in position, and the anaesthetic continued through the inlet tube on the gag with nitrous oxide/oxygen and halothane: the percentage of halothane varies from 2 to 1%, according to the age and general condition of the child, the amount of halothane being gradually reduced as the operation nears its end. In suitable cases there is no objection to inducing anaesthesia with a very small dose of thiopentone, provided no other sedation has been given pre-operatively.

The inexperienced or junior trainee anaesthetist often has difficulty in adapting the anaesthetic technique to the widely varying operative techniques used by different surgeons. In this area, and no doubt elsewhere,

children's tonsils are removed by the guillotine, variations of the snare method, or by plain dissection, so that the operation may take anything from two minutes to half an hour according to the particular method favoured by each individual surgeon. One way out of this difficulty is, of course, to induce with thiopentone and a muscle relaxant and intubate all children for tonsillectomy. However, the presence of an endotracheal tube in the pharynx of a small child is nearly always unpopular with the operator; and I remember a very senior and disgruntled ear, nose, and throat surgeon in days gone by who was wont to deal with such unwelcome diversions by cutting through the tube with scissors while dissecting out the tonsils.—I am, etc.,

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SIR,—The interesting findings of Dr. H. B. Holden and Dr. J. J. Maher (4 December, p. 1349) cause your leader writer to advocate that "small" children be offered fluids up to two hours before operation. Before the figures are accepted as evidence of actual fluid depletion they should be substantiated by proof that such children commonly lose 1–1.5 kg. of their body weight between admission and operation; had these children been accurately weighed one would have expected very different results.

Although no one would be likely to condone a 24-hour fluid intake of less than 200 ml., it is surely exchanging a doubtful benefit for a definite hazard to offer fluids, for example, at 5 a.m. to a child due to be operated on at 9 a.m.?

In the early stages of water depletion there is evidence that the blood volume is selectively maintained¹ and the accretion of intravascular water after moderate haemorrhage is probably more dependent on mobilization of stores of preformed albumin than upon relatively small oscillations in the volume of the total body water.—I am, etc.,

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REFERENCE

- ¹ Black, D. A. K., McCance, R. A., and Young, W. F., *J. Physiol.*, 1943, **102**, 406.

Prevention of Tetanus

SIR,—I was extremely interested to read the article by Dr. A. O. Lucas and Dr. A. J. P. Willis on the prevention of tetanus (4 December, p. 1333).

The evidence presented seems to show that in Ibadan at least the efficacy of antibiotic prophylaxis against tetanus does not compare with the efficacy of A.T.S. As you

are aware, following a paper by Cox *et al.*,¹ A.T.S. is regarded in many parts of this country as being relatively valueless as prophylaxis against tetanus, and it is recommended that antibiotics should be used in lieu. I think this new evidence should make the protagonists of antibiotic therapy stop and think very seriously about the wisdom of

encouraging the use of antibiotics instead of A.T.S. for prophylaxis.

Recently there was a leading article on the prophylaxis of tetanus in the *Lancet*.² In the subsequent correspondence a letter from Dr. R. L. Batten stated he was concerned "lest young and inexperienced doctors continued to put their faith in A.T.S." He also stated, "It is surely from a centre like Ibadan that we should hope for the real answers in prophylaxis." He has now received his answer, and it would seem better to put faith in A.T.S. than in antibiotics.

The real answer is, as all writers at present are agreeing, we must press for a more widespread active immunization by tetanus toxoid.—I am, etc.,

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REFERENCES

- ¹ Cox, C. A., Knowelden, J., and Sharrard, W. J. W., *Brit. med. J.*, 1963, **2**, 1360.
² *Lancet*, 1965, **2**, 999.

Mother and Child in Hospital

SIR,—In reply to the chairman of the National Association for the Welfare of Children in Hospital (20 November, p. 1245) I believe that much more careful and discriminating arrangements must be made before more accommodation ought to be provided for mothers and children to be together in hospital. A friend of mine was asked to leave her home and family 60 miles away for a week while one of her children was in a children's unit of a London hospital. The child, aged 7 years, was at the time in good general health, but tests were necessary to discover whether an important operation may be needed later. The hospital did not supply either accommodation or meals for the mother, who was left to make her own arrangements, which included an essential return home during the week. First of all my friend was told that she need not come to the ward on any day until the afternoon, and it was only once that she was asked to stay after tea-time. During her afternoon visits there was nothing for her to do, and like most of the other parents she sat beside her child's bed while the child was playing with most of the other children in another part of the ward, with the production of a painful amount of happy noise. One mother gave the staff a lot of help with laundry, and my friend protected a child, who was in bed soon after a big operation, from being banged on the head by a convalescent. So far as her own child was concerned, another close relative who lives in London visited once during the week and could have done so more often.

Even if this mother's residence had been in the only cubicle provided for mothers in the ward, her presence and that of most of the other parents who attended every day seemed inessential and ineffective.

I know of another large children's hospital where accommodation for mothers has been