Despite the different condition of our urban society, industrial therapy and social rehabilitation are essentially similar to the collective procedures that used to be called moral treatment of the insane, and it is salutary to recollect how effectively they were employed in the small asylums of Britain in the first half of the nineteenth century. In the Crichton Royal Hospital at Dumfries, the Lincoln Asylum, the Retreat at York, and at Hanwell Asylum the patients lived in therapeutic communities. More than half worked purposefully on projects useful to the community, and the personalities of the attendants were deliberately used in furtherance of social rehabilitation. T. P. Rees¹ pointed out that the results of moral treatment between 1820 and 1860 were astounding, the recovery rate often being two-thirds or more of all admissions. In 1847 J. Conolly² at Hanwell had worked out a complete philosophy of rehabilitation, hoping for but not achieving, "houses of cure—establishments intermediate between asylums and ordinary life, in which profitable labour could be supplied to some for a short time and to others for a longer period." He realized that what was wanted was "the means of placing the patient in a position favourable to resuming a course of successful industry."

Then as now there were difficulties and problems in staffing the workshops. Conolly as well as the authors of the King Edward's Hospital Fund survey recognized that "the work masters must exercise as much vigilance over those employed under them as the attendants do in the wards, and if new employments are resorted to work masters must be engaged."

Indications for Tonsillectomy

The very large number of tonsils and adenoids removed is in itself justification for inquiry into the advisability of the practice. A recent survey of school leavers carried out by T. M. Banham¹ in Cornwall concludes that this operation is justified, for 96% of the children operated on were improved. No doctor doubts the value of the operation when performed for right reasons, but it is the indications themselves that are controversial.

All tonsillectomy prevents is the development of further attacks of tonsillitis. Adenoidectomy removes the majority of lymphoid tissue from the nasopharynx and will benefit the child only if the adenoid mass had been large enough to obstruct the choanae or eustachian tubes. So the only absolute indications for tonsillectomy are a chronic quinsy or persistently large tonsils and adenoids that markedly interfere with swallowing or breathing. Apart from these rare conditions, repeated quinsies and frequent severe or persistently relapsing tonsillitis are acceptable indications to most surgeons. Recurrent or persistent deafness and otitis media, when associated with enlargement of the adenoids, indicates the need for adenoidectomy. Enlargement of the cervical nodes together with a history of recurrent tonsillitis is only confirmatory evidence. The operation, however, is done most often for recurrent tonsillitis in children between the ages of 4 and 7—the early school years when children are most subject to repeated viral upper respiratory tract infections. Virus infections at this age are often associated with sore throats due to pharyngitis and with aural and nasal symptoms, and it is important to distinguish this group from true recurrent tonsillitis, for tonsillo-adenoidectomy does not prevent virus infections of the respiratory tract. As tonsillitis is rarely a serious illness in this antibiotic era, surgery is rarely absolutely essential, and the children may often be left to acquire a natural immunity to these infections or can be protected by prophylactic chemotherapy. It is therefore in this group that practitioners, paediatricians, and otolaryngologists have even among themselves such divided opinions. Cases of allergic rhinitis or bronchospasm are frequently referred for tonsillo-adenoidectomy, but most of these patients are made no better and some worse by surgery, the exception being when each allergic response can be directly related to an attack of frank tonsillitis.

Selection of cases for surgery depends largely upon careful history-taking, since at the time of examination at hospital the acute lesions have usually abated. Clinical examination is particularly useful for assessing the state of the upper respiratory tract and ears between acute attacks and eliminating other possible diagnoses. The appearances of the tonsils or the presence of debris within the crypts are no criteria of the amount of trouble the tonsils have caused. Too often the factual and fully descriptive information which should be contained in the accompanying doctor's letter is not available.

Statistical evidence has shown that the incidence of tonsillo-adenoidectomy varies between social classes and communities, a fact which suggests that not only do the indications vary from surgeon to surgeon but that social and financial pressures may influence the surgeon's judgement. Many parents, practitioners, and other authorities regard the removal of tonsils and adenoids as being without risk and also as a possible panacea for all respiratory ailments. The great risk is that the operation may be done merely to satisfy the parental and practitioners' wishes rather than to benefit the child, particularly as the consultation frequently takes place in a busy outpatient clinic. Surgeons, however, can maintain strict indications by deferring decisions when in doubt and reviewing patients on waiting lists.

The operation itself is not without hazard, for it carries a mortality rate of 1 in 10,000.² Death most commonly results from anaesthesia, reactionary or secondary haemorrhage, or inhalation of blood clot. Reactionary haemorrhage may be worrying or even dangerous when not recognized early. The loss of blood during operation may at times be considerable, and the resulting anaemia increases morbidity. To minimize these risks otolaryngologists do their best to operate only in well-equipped hospitals with good medical and nursing staff. Though standards of surgical care are being continually raised this does not excuse relaxation of the indications for surgery. Far too many tonsils and adenoids are still removed, but, as there are no finite pathological or clinical criteria by which to judge, the decision to operate is still a matter of opinion. The final medical opinion must be the surgeon's, but the question and the aims of surgery ought to be fully discussed with the parents, for it is their choice also.

As surgical problems tend to be referred to the surgeon and medical ones to the paediatrician further clarification is likely to occur only if they fully co-operate in a well-planned survey.

1 Banham, T. M., J. Laryng., 1968, 82, 203.