SIR MORELL MACKENZIE ON THE TREATMENT OF ACUTE AND CHRONIC TONSILLITIS.

On Tuesday, December 4th, Sir Morell Mackenzie visited the throat clinic at the Edinburgh Eye, Ear, and Throat Hospital. He examined a number of the patients, and in the course of a short clinical lecture made the following remarks:

There are two forms of acute tonsillitis, the superficial and the deep. All of you must be well acquainted with these familiar diseases, but perhaps you will like to hear my experiences of the treatment. The superficial is not very serious; it is, however, painful, and it is apt to recur; a person who has had it once is very likely to have it again. This is true of both forms of tonsillitis, but is particularly so of the superficial. The interior of the follicles becomes inflamed and secretes an unhealthy mucus, and they never thoroughly recover. In all inflammations of mucous membranes the membrane does not really get well, though it may appear to do so. A celebrated French surgeon has said that he does not believe that a person ever really recovers after a gonorrhœa. This is true of the follicles of the throat. A person who has once had acute tonsillitis never really gets well, though he may appear to do so. The treatment, therefore, is important. One of the most popular remedies is aconite—originally, I believe, a homeopathic drug, but now used extensively by allopaths (though I object to the term)—and strongly recommended by Dr. Ringer. It has certainly never, in my hands, proved to be of the extraordinary value which he asserts. On the other hand, I have found guaiacum, which used to be given in the form of the ammoniated tincture, very efficient. I recollect a Manchester surgeon, Dr. Crompton, who used to come a good deal to the Throat Hospital about the time it was founded, telling me I should find much more benefit in giving it in the form of a powder; and I did so, letting the patient take a pinch of the resin. This was rather disagreeable, and after a time I had it made into lozenges containing about three grains in each. In this form it makes an excellent remedy. Nine cases out of ten will get rapidly well if one of these lozenges is given every two hours at the outset. I sometimes also apply locally a little bismuth and opium, or an eighth of a grain of morphia with a quarter of a grain of starch, because the problem is not only to cure the patient, but to keep him comfortable till he is cured. Sometimes the guaiac causes a little diarrhœa, which is not altogether disadvantageous, but the morphia is usually sufficient to check it. What I have said about guaiac applies to acute inflammation of any part of the back of the throat. Dr. Home has said of guaiacum, "*Instar specifici in hoc morbo operatur.*" It is really specific. I have used it for fully twenty years, and I assure you it is one of the best remedies you could have. It causes a slight stinging sensation, and this is an additional reason for using the morphia.

Occasionally this superficial or follicular tonsillitis, if not checked, passes into the deep or parenchymatous form, and the structure of the gland becomes very much affected. When the deep inflammation occurs you must bring it to an abscess as quickly as possible, and open it. Trousseau has pointed out that some inflammations *begin* in the deep part of the gland, and these you can't check, as a rule, though you may sometimes succeed with guaiac. I have done so in two cases lately. We are usually, however, called in too late. When you find you can not stop the disease, give inhalation of benzoin, hop, or conium, and apply poultices to the outside of the throat. Directly you can see fluctuation, make an opening. As the tonsillitis develops it prevents the patient opening his mouth, and there is some difficulty in getting at the abscess. This is the reason why surgeons sometimes have to let the abscess burst, but this should be avoided, if possible, because it has been followed by dangerous and even fatal hemorrhages. I generally use a curved and guarded bistoury, of which only the last quarter of an inch has a cutting edge, but an ordinary bistoury, the greater portion of the edge of which is covered with diachylon, may also be used. The incision is made with the cutting edge directing inward to the center of the mouth. You must never cut outward, for there is then the danger of wounding the carotid. I would recommend you to incise in cases in which you may be quite certain of fluctuation. A slight puncture, even if pus is not evacuated, does no harm. The use of leeches was at one time common, but Louis the French physician proved that they did not cut short the disease by more than one day, and therefore their application was not desirable. Leeches have the effect of increasing the inflammation rather than otherwise if less than six are applied. Chronic tonsillitis, or hypertrophy of the tonsils, proceeds from two causes. A large number of the cases are the result of a low form of inflammation occurring in childhood. The structure in childhood is very prone to become inflamed. If the tonsils are considerably enlarged, it is important to remove a portion of each. You should never speak of "cutting out the tonsils," as this sounds very alarming to the patient and his friends. Say that you mean to remove only "the diseased and enlarged portion." It is a consideration, when you should do this, how much enlargement should there be before the operation is performed? First of all the question of size is entirely relative. In a large throat the tonsils may grow to a considerable size, and the patient still do quite well. In a smaller throat this would not likely be the case. If the tonsils touch each other you can have no doubt as to