The Post-Operative Treatment of Adenoids.*

By Macleod Yearsley, F.R.C.S.,
Surgeon to The Royal Ear Hospital, &c.

Since the discovery of adenoids in 1868 by Mayer, of Copenhagen, so much has been written upon the pathology, symptomatology, and treatment of hypertrophy of the pharyngeal tonsil, that one would almost look upon the subject as threadbare.

One hears so often, however, of cases in which the growth is reputed to have recurred or in which its removal has not been attended with the results to which both operator and patient have looked forward, that a few words upon the necessity of care and appropriate treatment after the "adenoid operation" will not be superfluous and would probably prove useful to many.

I have elsewhere expressed myself as strongly of the opinion that adenoids very seldom genuinely recur. In certain cases, scattered sparsely through the literature of the subject, genuine recurrence has taken place after complete removal, but in these instances there has usually been a special reason for the phenomenon. Such a case is that related by Lermoyez†, in which what appeared to be adenoids in a child were twice removed, each removal being very soon followed by recurrence of symptoms. The tissue obtained at the second operation was found to be tuberculous, and not to have the characteristic adenoid structure, whilst tubercle bacilli and giant cells were abundant.

Such cases are decidedly rare, but there are such things as false recurrence and recurrence of symptoms, conditions which are eminently preventable, and which it is my purpose to here discuss.

Let us first deal with what I have designated as *false recurrence*. By this I mean the growth of tags left by a former imperfect operation. I may here remark that whenever I hear of the return of adenoids, one's first thought is, and one nearly always finds, that thorough clearance of the post-nasal space had not been effected. Such cases often occur when the finger-nail alone has been used. A good instance of this false recurrence —*i.e.*, the growth of lymphoid tissue left by imperfect operation—came under my observation some two or three years ago. The patient, a boy of fourteen, was operated upon for adenoids five years before, after which a chronic suppuration in the left ear cleared up, and had not since recurred. On examination with the posterior rhinoscope a few tags of growth were noted at the margins of the pharyngeal vault. As there were no symptoms to justify further operation, inaction was advised, and the boy kept under observation. All went well for nearly a year, when he was attacked by scarlet fever. Examined after the illness, it was found that he was becoming deaf, and that the tags had greatly enlarged, necessitating removal.

This could hardly be called "recurrence" in the true sense of the word.

In an exhaustive article on this subject by Bliss* is pointed out a fact with which my own observations are in accord and to which I would especially direct your attention. In each case the patient's whole aspect corresponded to the condition termed "strumous," an apparent failure in those vital processes which tend to complete development in the body structures and the maintenance of integrity of tissue. I shall allude to this significant fact again, for it has a very important bearing upon treatment.

The *recurrence of symptoms* may be due to one of three causes—

1. Continuance of the mouth-breathing habit.
2. Projection forward of the atlas and axis.
3. Nasal obstruction from other causes.

The continuance of the mouth-breathing habit is a condition which is usually easily met by discipline and breathing exercise, but it should never be taken for granted as present unless careful examination shows other causes of nasal obstruction to be absent.

Projection forward of the atlas and axis cannot, of course, be remedied. Nor can the narrow, pointed, "pent-house" naso-pharynx that is sometimes met with. But in these cases any forward stoop or slouching habit of carriage should be corrected, and the breathing exercises to be detailed later carefully persevered with. In such cases as these one should always eliminate all possibility of obstruction to breathing in the nasal passages. Such patients have naturally small post-nasal spaces, owing to their form or to the undue projection of the first and second cervical vertebræ, and should be given every facility for using all the nasal breathing-space they can command.

When symptoms persist or recur from causes of obstruction other than those situated in the naso-pharynx, treatment should obviously be directed to their correction, and need not detain us here. Such obstruction may be due to congenitally narrow nares, to enlargement of the posterior ends of the inferior turbinal bodies, to enlargement or engorgement of the whole of the inferior or middle turbinals, to septal deviations, &c.

As a matter of fact, no case of adenoids should be taken as a case of adenoids *per se*; a thorough examination should be made of the whole respiratory tract, and the patient treated according to the results of that examination. Were this always done, there would be fewer cases of either true or false recurrence, or of recurrence of symptoms. Nor should too much reliance be placed upon the mere

* A Clinical Lecture delivered at The Royal Ear Hospital.

† *Ann. des Maladies de l'Oreille, &c.*, 1894, p. 979.

* *New York Medical Journal*, October 29th, 1898.

previous page next page