The Journal of Laryngology & Otology

cambridge.org/jlo

Regarding 'The impact of new evidence on regional variation in paediatric tonsillectomy and adenoidectomy: a historical review' by van Munster et al

L Dwyer-Hemmings

Institute of Medical and Biomedical Education, St George's Hospital, University of London, London, UK

Letter to the Editors

Cite this article: Dwyer-Hemmings L. Regarding 'The impact of new evidence on regional variation in paediatric tonsillectomy and adenoidectomy: a historical review' by van Munster et al. *J Laryngol Otol* 2021;**135**: 370–371. https://doi.org/10.1017/S0022215121000724

First published online: 17 March 2021

Dear Editors,

I recently read an article published in your journal, by van Munster *et al.*, which presented an informative insight into the historical aspects of regional variation in tonsillectomy.[1] Tonsillectomy is a widespread procedure surrounded by a decades-long controversy regarding variation in practice. I agree with their conclusions that international efforts are needed to establish greater clarity on the causes of this regional variance; however, I wish to draw from the UK experience to demonstrate some explanatory factors, and to suggest further causes for the increase in tonsillectomy incidence at the start of the twentieth century.

Glover's 1938 article was the first of several attempts to account for geographical variation in tonsillectomy rates,[2] and this led to numerous initiatives from the UK's Medical Research Council to analyse and explain this phenomenon. The Medical Research Council facilitated a survey of school medical officers in the late 1950s, which demonstrated not only extensive geographical variance in school-age children who had undergone tonsillectomy (between 0.5 and 25 per cent), but also significant variance with socioeconomic status (incidence ranged from 14.3 per cent in technical schools to 37.9 per cent in grammar schools).[3] Later in the century, the Medical Research Council commissioned an investigation by medical sociologist MJ Bloor. Bloor's study identified greater variation between medical practitioners in a single geographical location, compared with between locations,[4] which he explained through specific differences in assessment and decision-making strategies between clinicians.[5] This reinforced Glover's original conclusions that differences in rates were accounted for by differences in medical opinion.

At the start of the twentieth century, tonsillectomy rates rose rapidly. As van Munster *et al.* report, this was partly due to the dominant epistemology at the time – the focal theory of infection, which attributed systemic illness to local disease. However, several other factors influenced this new popularity. In the UK, an increase in the medical surveillance of children (e.g. through the School Medical Service) occurred just as medical services were becoming more accessible with social programmes such as the National Health Insurance Act (1911).[6] This facilitated greater identification of tonsil disease in children, while also making interventions available financially to a broader section of the population. Furthermore, it was during this period that otorhinolaryngology was formalised as a specialty, and this surgical procedure on the tonsils – where the ears, nose and throat meet – would anatomically represent this evolving discipline.[7] As I have argued elsewhere, the focal theory played an important role in the popularity of tonsillectomy; however, there were also important structural, financial and political incentives for the growth of the procedure.[8]

Attention to the UK's historical experience allows us to gain an understanding of the factors implicated in the geographical variance of tonsillectomy rates, and helps explain why variance persists despite stricter indications and guidelines. The role of socioeconomic status and practitioner decision-making must be accounted for in future research in this area, and attention to these factors will facilitate evidence-based reflective practice and ensure that interventions are appropriate and justified.

References

1 van Munster JJCM, Zamanipoor Najafabadi AH, Schoones JW, Peul WC, van den Hout WB, van Benthem PPG. The impact of new evidence on regional variation in paediatric tonsillectomy and adenoidectomy: a historical review. *J Laryngol Otol* 2020;**134**:1036–43
2 Glover JA. The incidence of tonsillectomy in school children. 1938. *Int J Epidemiol* 2008;**37**:9–19
3 Henderson P. Frequency of tonsillectomy in children. *The National Archives* 1957;FD23/618
4 Bloor MJ. Extract from a report on an epidemiological and sociological study of variations in the incidence of operations on the tonsils and adenoids. *The National Archives* (no date); FD23/4930

5 Bloor MJ. An investigation of variation in adeno-tonsillectomy assessments between ENT specialists. *The National Archives* (no date); FD23/4930
6 Webster C. *The National Health Service: A Political History*. Oxford: Oxford University Press, 2002
7 Yalamanchili S. Why should disorders of the ear, nose and throat be treated by the same specialty? Can this situation persist? *J Laryngol Otol* 2009;**123**:367–71
8 Dwyer-Hemmings L. 'A wicked operation'? Tonsillectomy in twentieth-century Britain. *Med Hist* 2018;**62**:217–41

https://doi.org/10.1017/S0022215121000724 Published online by Cambridge University Press