AUSTRIAN OTOLOGICAL SOCIETY.

25th October 1926.

(*Monatschrift für Ohrenheilkunde*, December 1926.)

Abstract of Proceedings by Mr A. R. TWEEDIE, F.R.C.S.

Diffuse Purulent Latent Labyrinthitis on one side; Diffuse Serous Secondary Labyrinthitis on the other side, following Scarlet Fever: Labyrinth Operation: Recovery — E. RUTTIN. — Girl, aged 7 years, was admitted on 23rd July 1926. She had scarlet fever early in June; eight days later, bilateral otorrhœa without much pain, but a swelling noticed behind the ears prior to the discharge. As she had a very high temperature the range of her hearing was not determined; but fourteen days after the beginning of her illness her hearing was extremely bad on both sides; while two weeks later, the face was paralysed on the right side. One week later, she was able to get up but was extremely giddy.

On admission, the meatus on both sides was filled with granulations and thick non-offensive pus. Right ear, totally deaf to speech and tuning forks; left ear, loud voice only *ad concham*.

No spontaneous nystagmus; facial paralysis, right; reversed fistula symptom, left, with which was associated vertical upward nystagmus on compression; caloric reaction, negative on both sides; on rotation, possibly slight traces of reaction as regards the horizontal canals, but the superior canals did not respond, nor was there any giddiness, head or body reaction. The patient was in a miserable condition, and complained of headache, suggestive of meningitis.

In accordance with the above symptoms, with the report of recent and continued fever and mastoid tenderness, operation on the right mastoid was decided upon. A fistula was found on the mastoid surface, while the mastoid process contained pus, granulations and four sequestra. Later a fifth sequestrum was removed, which represented almost the whole horizontal canal; this exposed the labyrinth. The oval window was also empty. The horizontal portion of the facial nerve lay exposed, as did also the lateral sinus and dura mater of the posterior and middle fossæ, all of which were covered with granulations. Neumann's labyrinth operation was forthwith performed, and the promontory removed, but without any flow of fluid. After the operation there were no labyrinth symptoms and no nystagmus. Healing of the wound was normal.

18.8.26. — Polypus was removed from the left ear; right ear, deaf. Left ear, c.v. at $\frac{1}{2}$ metre. Weber to the left, no spontaneous nystagmus or by-pointing. Caloric reaction on each side, negative.

https://doi.org/10.1017/S002221510003084X Published online by Cambridge University Press

Rotation: (apparently head erect) no nystagmus except slight reaction after rotation to the right. With face downwards; rotation to the right, slight nystagmus, but no giddiness or body reaction. Rotation to the left, no nystagmus, no giddiness, no head or body reaction.

Fistula symptom, left positive but reversed.

21.10.26.—Right ear healed and epidermised. Left ear, large central perforation with red mucous membrane and slight secretion; right ear, deaf; left ear, c.v. at 4 to 5 metres. Whisper 1.5 metres. Weber to the left. Caloric reaction left, positive but very weak.

Fistula symptom, left, positive; resulting in two course vertical movements downwards on compression followed by horizontal movements to the left. On aspiration, a slow movement of the eyeballs to the right. No spontaneous nystagmus or by-pointing.

On rotation to the right, nystagmus to the left, 2 or 3 jerks.

On rotation to the left, nystagmus to the right, 2 or 3 jerks.

With the head inclined to the side and face downwards, no nystagmus, no giddiness, no head nor body reaction.

Thus at the first examination, there existed on the right side a diffuse purulent latent labyrinthitis, and on the left side a circumscribed diffuse serous secondary labyrinthitis.

The tenderness of the mastoid process on the right side and meningeal symptoms afforded indication for the operation.

Acute Otitis with Neuritis of the Cochlear and Vestibular Nerve—E. RUTTIN.—Girl, aged 10 years, had suffered from pain in her left ear since the 1st October 1926, without headache or vomiting but with considerable fever. Three days later, paracentesis: the left tympanic membrane was reddened and infiltrated.

Hearing: c.v. at 3 metres: Whisper at $\frac{1}{2}$ metre; Weber to the left; Rinné, left negative; Bone conduction, left, lengthened. No spontaneous nystagmus, dizziness or fistula symptom.

She was sent home and treated as an out-patient. Six days later her doctor brought the child again and reported that she had a high temperature, tender mastoid, and some torticollis.

On re-examination: meatus eczematous, tympanic membrane injected, incomplete deafness in left ear.

Weber, not lateralised; Rinné, negative.

No spontaneous nystagmus and no fistula symptom.

Rotation reaction normal on both sides. Temperature 39 C. Mastoid process tender, torticollis (the child holding the head to the right). Right ear normal. Temperature in the evening normal.

On the 18th October no sign of torticollis; left ear deaf.

On the 22nd October loud voice heard at $\frac{1}{2}$ metre. No spontaneous nystagmus or caloric reaction.

https://doi.org/10.1017/S002221510003084X Published online by Cambridge University Press

Rotation with the head erect—

To the right gave nystagmus to left, 12 seconds.
,, left ,, ,, ,, right, ,,

With face downwards—Rotation to right gave a downward directed nystagmus 1.5 seconds. Giddiness and typical head and body reaction; rotation to the left gave a rotatory nystagmus to the right, 6 seconds. Giddiness, typical head and body reaction.

Rotation to the right—

With head on the right shoulder, a vertical, downward nystagmus, 6 seconds.

With head on the left shoulder, a vertical, upward directed nystagmus, 4 seconds.

Typical giddiness, head and body reaction.

On the 23rd of October, hearing still only *ad concham;* temperature not raised since the 12th October.

The exhibitor considered the case was one of acute otitis media and the cause of the torticollis was to be referred to inflammatory conditions of the lymphatic glands. He pointed out that the incidence of the almost complete deafness coincided with the appearance of torticollis, and further that as the deafness was only slightly improved, it could not be the result of an inflammatory middle-ear lesion alone. A serous labyrinthitis could be excluded by the vestibular reactions obtained. Hysteria also was improbable, although no caloric reaction could be induced.

He therefore considered there could be no other cause than a toxic neuritis.

Deaf-Mutism following Whooping-Cough.—Dr MARKUSSAN. —A male, aged 19 years, had whooping-cough at 4 years old, followed by deaf-mutism; otherwise patient is perfectly healthy; has no appreciation for either speech or tuning-fork, and both labyrinths are completely reactionless. On standing, walking forwards or backwards with eyes shut, is very unsteady. Wassermann reaction negative. Physician and oculist report normal conditions.

The interesting point was the etiology of the case. From the history there had been apparently no meningitis, and although it was difficult to say exactly what was the true cause, one would not suppose that such a sudden bilateral paralysis of the labyrinth function could be due to a hæmorrhage. He therefore considered the cause must be some central toxic lesion or a toxic neuritis.

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