SESSION VI

State of the Art

https://doi.org/10.1017/S1755146300090697 Published online by Cambridge University Press

Conclusion

by

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It was my pleasure to conclude the meeting of the First International Tinnitus Seminar, that Abe organized here in New York and again the pleasure accrues to me to conclude this one. I think that there are a few salient points that can be drawn from the differences between the two.

The most striking thing to me was that when Abe organized the first meeting and asked a number of us to contribute something about tinnitus. I suspect that the vast majority of the people who came and read papers, had not really looked into tinnitus for a very long time. We sought among our documents in a retrospective attempt at looking back into our operations, and amongst our patients, for points regarding tinnitus. Well, this year it has been completely different because virtually everybody who has spoken here has done some work in the meantime with the specific intention of investigating tinnitus. And I think in simply bringing about that transformation, Abe has made quite an outstanding contribution to the study of tinnitus on an international scale. I think that, even if he stops at this, which I hope he won't, his contributions have really been quite immense.

Another thing that struck me was the selection of the Guest of Honor, whom I suspect Abe chose himself. Both the previous one, Jack Vernon, and Juergen Tonndorf are quite unique as Guests of Honor because they have actually contributed something of importance themselves. Juergen's description of the high frequency audiometer (and I like to call it an electrical audiometer) is extremely striking; something quite unexpected. I don't know if Juergen is still here, but if he is, I will say that we usually don't expect this from Guests of Honor. They are generally chosen because they are at the end of their tenure completely, otherwise, why shower them with honors. They become almost a threat. But here again is a very striking exception and departure. Now, I was particularly pleased to see here Bilger, Tyler, and Jos Eggermont. I feel that this will mean that, in the coming years, we are going to see a very much better definition of tinnitus both in their terms and in electrophysiological terms. I have this feeling that their contributions will be of great value to us. We have heard a great deal about objective techniques, acoustic emission measurements, electromagnetic patterns, ABR, cochleovestibular correlations, rotating chairs and so on. I think that there is perhaps a surfeit of techniques and mechanisms coming in from all sides. Most of us can only afford one of these things, if that. Since we are being showered by 'goodies' in a sense, I think we have to look at them with awe, with pleasure because new techniques are bound to demonstrate new findings, but we have to also approach them with some caution. With the same objective technique we have to interpret the findings. This is where the trouble may appear. The paper that Abe Shulman produced on changes in the ABR is extremely important. It is the first objective test of changes that are measurable in patients with tinnitus. It must be investigated very cautiously. It's too important to simply just take it or leave it. I think that those who are interested in ABR's particularly, ought to delve into the meaning of these findings. We must not

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dismiss them, for example, because of the audiogram results; or say they occur in people who do not have tinnitus. But if they do occur, what do they represent? If drugs make them disappear, are these in fact the same drugs that make tinnitus disappear or are they just simply drugs that affect the brainstem, and therefore alter their results?

I think that this is much too important a point to overlook at this stage. But where caution must be exercised regarding all these things, rotating chairs, ABR's and so on, is in their place in the diagnosis of these conditions. Perhaps I could relate this to liver divination. Some of you may know that in early Greek, early Roman times, they used to remove and inspect the livers of animals in order to decide whether they should go to war that day or not. Now it's easy to laugh it off and say this is absolute nonsense. How can the liver tell you such things? But believe me there were no faults. Julius Caesar won his battles. Pompei won his battles. They knew what they were doing. So what do we say? Was liver divination a correct technique and could we apply that to the diagnosis of tinnitus? Cut up a sheep and have a look. If we look carefully at what they did, we would see that they looked at the liver of a sacrificial animal, they looked at the weather, they looked at the conditions that were prevailing, they looked at the strength of the army. They investigated many, many factors and they looked at the liver, and they kept records, and they correlated these with the previous cases which the priest had kept records of and then made their decision. In all of this, the liver plays a role and it was easy for the priest, at the end of all of that, if they won the battle, to say: "you see—we were right".

Now I think this can be related to some of our tests. Those of us who were enamored of the ABR, can use that as liver divination and produce an excellent diagnosis and perfect management and success of the patient, and believe that it is because of the ABR. The same applies to those who use the rotating chair or biochemical analysis or other methods. They get good results because they are good doctors and know how to handle their patients, and not because they have a special machine. That doesn't mean we ought not to have it. It simply means that we ought to understand that it is one parameter amongst many and often not the most important.

So we come to the various forms of treatment. Now we have patients battering at our doors, demanding treatment sometimes threatening suicide. I have one patient now who telephoned me before I left and said: "I know you are going to this meeting in America and I have made an appointment to see you when you come back so you can treat me with the most modern equipment". He failed at treatment with a masker, and electrical stimulation has not succeeded. He is now begging me to cut his nerve. He thinks the odds are not bad. What should be done? These pressures upon us mean that we ourselves become almost desperate and will tend to use virtually any treatment that is suggested by anybody. These treatments all have a place —whether it's the masker, electrical stimulation or even psychological support, when we have the patience to give it to them. Whether it is drugs or whether it is surgery. What we ought to question is whether the patients who respond to the maskers are the same patients who respond to electrical stimulation or to psychological support? In other words, are some people simply curable and other people not curable? Or do different groups respond to different things. This is a little practical guideline that we could ask of ourselves as we treat our patients.

To conclude, I would like again to paraphrase the words of a 12th century physician, Maimonides, who was asked whether it was permitted to use spells and magical things on the Sabbath. As a good physician he wrote an extremely long discourse on how stupid it was to believe that magic could cure anybody. Here is an Aristotlean, a person of great sense and he demolishes the use of magic point by point. But at the end of that he says: "but of course if you think it will help our patients, then you can use magic even on the Sabbath". We should not be ashamed to use magic if we think it's going to help our patients, even on the Sabbath; but what we must not do is fool ourselves.

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