Austrian Otological Society

AUSTRIAN OTOLOGICAL SOCIETY.

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

Facial Paralysis during Acute Otitis Media—L. HOFFMANN.—Boy, aged 10, had acute otitis media (left) commencing 18th April 1928, for which paracentesis was performed three days later. Profuse flow of secretion followed and the temperature fell from 38.5° C. to normal. Four days later there was sudden, complete left facial paralysis. Taste and movement of the velum were unaffected, but pain in the ear, tenderness over the mastoid, and profuse otorrhœa were present; hearing was reduced to C.V. air conduction.

In spite of the unfavourable conditions, the sudden onset of complete paralysis was regarded as rheumatic in origin. The following day there was marked improvement of the local symptoms and gradually the paralysis recovered.

At the present time the ear is completely healed and only a slight paresis of the left eyelid remains. The exhibitor drew attention to the fact that the diagnosis of sudden, complete facial paralysis was regarded as "rheumatic" in origin in accordance with Neumann's teaching, and that this view has been confirmed as correct by the subsequent course of events.

Extraordinary Rapid Repair of a Large Defect of the Tympanic Membrane—L. HOFFMANN.—Patient was an infant on whom paracentesis had been performed on the 3rd May, for relief of a typical acute otitis media. A week later, as the otorrhœa was so profuse, the ear was irrigated, when the lotion passed into the nose and was swallowed by the child.

Examination then revealed that the defect involved more than half of the membrane and that the mucous membrane of the middle-ear was slightly swollen.

Nine days later the ear was dry and the tympanic membrane completely restored, the defect being merely represented by a small scar. The exhibitor argued, therefore, that an unfavourable prognosis was not always necessary in these cases.

Acute Otitis Media: Mastoiditis: Congenital Atresia of the Meatus—E. SCHANDLER.—Girl, aged 23, who had suffered from mumps, measles, and chicken-pox during infancy, and iritis at the age of 15, was taken ill on the 21st March 1928, complaining of severe headache, giddiness, shivering, and presumably fever.

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22nd March.—Temperature 38.6° C.: 25th March, severe pain behind the right ear: 27th March, was admitted to hospital. Temperature 39.6° C.; pulse 120.

Examination of right ear showed atresia of the meatus dating from birth, since when this ear had been totally deaf; hypoplasia of the auricle; extreme tenderness of the whole mastoid process.

Left ear was normal.

No spontaneous nystagmus was present.

Rotation test:—Head erect, rotation to R. 45 "jerks," to the L. 50 "jerks."

Face downwards, rotation to the R. 45 "jerks," to the L. 29 "jerks."

Rotation with head on the shoulder not tested owing to the condition of the patient. The condition of the ear, the teeth, and the unequal size of the pupils suggested lues, whilst from the general condition and history, the diagnosis of recent influenza was made.

28th March.—Slight giddiness; frontal headache; temperature 38.5° C. X-ray examination revealed aplasia of the os tympanicum; moderately cellular structure of mastoid, the cells reaching into the squamous bone and also forwards into the neighbourhood of the external meatus, and backwards over the sinus. No definite sign of bone affection was present and the sinus was in normal position.

29th March.—Generally improved; mastoid process less tender; very slight headache, no giddiness; temperature 33.6° C. Cerebro-spinal fluid was normal.

30th March.—As blood examination revealed no cause for the continued temperature, and as pus from the mastoid process afforded a vigorous growth of hæmolytic streptococci, operation was undertaken, when the following condition was found:—Normally developed mastoid process; cortex thin; the first blow of the chisel evacuated fluid pus which extended throughout all the cells. One cell group extended over the situation of the meatus into the root of the zygoma, from which position one located with the probe, about the site of the attic, a cavity the size of a small pea, which reached forwards into the tube, but was bounded towards the area of the tympanum by bone.

The position of the horizontal canal appeared unusually deep.

12th April.—Wound almost closed. Patient discharged from hospital in excellent general health.

Chronic Suppurative Otitis Media (Left): Cholesteatoma: Necrosis of the Labyrinth: Operation; Recovery of Facial Paresis—E. SCHANDLER.—Male, aged 25, had suffered from occasional left otorrhœa since measles at the age of 2 years. Otorrhœa has continued for the last three years.

Since the 7th January 1928, giddiness, headache, pain in the left ear, but no fever, have been complained of.

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Examination showed nose and pharynx normal.

Right ear, "dry" perforation in postero-inferior quadrant.

Left ear has profuse purulent secretion; no external tenderness; meatus very narrow. A polypus surrounded by recent granulations. No view of fundus is possible.

Hearing in right ear, conversation at 3 metres: whisper at 1 metre.

Left ear, note A. is heard by voice.

Weber to the right. Spontaneous nystagmus to the right; no fistula symptom.

Rotation to the right, nystagmus 26 secs.; to the left, nystagmus 30 secs.

X-ray examination shows mastoid process is not pneumatic; antrum moderately enlarged; roof of antrum posteriorly not outlined; bone over lateral sinus normal. Sinus is displaced forwards.

12th January —Patient vomited during the night, during which blood and cholesteatomatous material were discharged from the ear. Mental condition is normal; no fistula symptom. Fundus of both eyes normal.

As the condition did not improve, the patient was admitted to hospital on the 10th April, with the report that on the 2nd April he had had severe headache on the left side, and that since the 4th April he had suddenly developed paralysis of the left facial nerve.

On examination, the facial paralysis was found to be complete and involved all three branches.

11th April.—Operation under a local anæsthetic. Mastoid process was sclerotic; granulations in antrum and attic; cholesteatoma in the antrum. Radical operation was followed by labyrinth operation, when the granulations were found over the horizontal canal, extending into and filling the vestibule.

17th April.—Facial paralysis markedly improved.

31st April.—Patient discharged with improvement in the buccal branch of the facial nerve, but the paralysis of the orbital branch still remained unaltered.

Bilateral Hennebert's Fistula Symptom with Vertical Nystagmus on Simultaneous Compression — M. TAMARI. — A girl, aged 28, reported at the hospital with the history that since early childhood she had suffered from continuous bilateral otitis media. Six years ago, on account of deafness, she had the posterior ends of the inferior turbinals removed in another hospital. In October 1922 she had been treated in an Eye Hospital for keratitis parenchymatosa. At that time the Wassermann reaction was negative, but the luetin test was positive; therefore treatment was carried out with the combination of mercury and salvarsan, which led to an undoubted improvement of the corneal opacities and vision.

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For the last two years she had suffered from tinnitus and giddiness. The tinnitus was continuous, but the giddiness occurred chiefly in the dark or in connection with sudden movement of the head or body. For the last year and a half there had been rapid increase of the deafness, especially on the left side. Inspection of tympanic membrane on each side revealed a large central perforation with opacities in the posterior portion.

Hearing: Left ear, complete deafness for speech and tuning forks; right ear, whisper 1½ metres; conversation at 3 metres.

No spontaneous nystagmus; no nystagmus induced by movement of the head.

Rotation to the left, nystagmus to the right 12 secs. with typical by-pointing.

Rotation to the right, nystagmus to the left 10 secs. without by-pointing.

Caloric reaction was not tested on account of the dry perforation.

Galvanic reaction with 2.5 m. amps. revealed horizontal rotatory nystagmus with typical by-pointing and dizziness on each side.

Air compression on each side evoked a typical, marked rotatory nystagmus, but the response to aspiration was negative.

By simultaneous bilateral compression, carried out by means of a Y-formed rubber tube, a vertical nystagmus upwards was induced with transient dizziness.

Otological Condition in a Case of Carcinomatous Leptomeningitis of the Cerebellum—E. RUTTIN.—Woman, aged 66, was referred on 4th April 1928 to the exhibitor with the diagnosis of tumour of the brain, for further examination, with the following history. She was always healthy until seven weeks ago when she felt shivery and sleepy, accompanied by loss of appetite, vomiting, and headache. Presumably she also had an attack of giddiness. Since then her hearing had been depreciated on both sides, whilst she had suffered from tinnitus for some years.

Examination showed the left ear with tympanic membrane normal; deaf for speech and tuning forks; Weber not lateralised; bone conduction much shortened. Caloric reaction at 18° C. after three minutes; no nystagmus. Thereafter typical by-pointing with both arms to the left; no giddiness, no vomiting, and no discomfort; left facial paralysis.

Right ear showed tympanic membrane normal; conversation at 3 metres; whisper at 1 metre. Rinné positive; bone conduction shortened; caloric reaction at 18° C. after 15 secs.; typical but weak nystagmus lasting 45 secs. Therewith typical by-pointing to the right with both arms. No giddiness, no vomiting, no discomfort.

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Spontaneous vertical nystagmus. Rotation tests:—

Rotation to the right, head erect, nystagmus to the left, 6 secs.
Rotation to the left, head erect, nystagmus to the right, 6 secs.
Rotation to the right, face downwards, nystagmus to the left, 4 secs.
Rotation to the left, face downwards, nystagmus to the right, 4 secs.
Rotation to the right, head on right shoulder, vertical downward nystagmus, 3 secs.
Rotation to the right, head on left shoulder, vertical upward nystagmus, 2 minutes.
No discomfort produced; no head or body reaction.

Diagnosis was made of a lesion of the auditory nerve on each side; total deafness on the left side; a lesion of vestibular nerve on both sides.

The otological condition suggested the probability of a basal affection. ? Lues.

The patient died and the post-mortem examination revealed a superficial carcinomatous infiltration over both cerebral hemispheres, the primary growth being apparently in the pancreas.

ABSTRACTS

THE EAR.

On the Occurrence of Gaucher Cells in the Petrous Bone with Remarks on the Causal Genesis of Otosclerosis. H. BRUNNER, Vienna. (*Zeitschrift für Hals-, Nasen-, und Ohrenheilkunde*, Band xxii., Heft 1.)

A case is described of Gaucher's splenomegaly in which death ensued; on microscopic examination of the petrous bone a patch of typical otosclerosis was found, with, in addition, Gaucher's cells in large numbers in the reticular medullary spaces of the bone. The case seems to be a unique one. Tinnitus developed in 1916, pain in the ear in 1923 with ordinary acute otitis. A considerable amount of dullness of hearing followed. The patient subsequently developed a condition suggestive of typhoid, with extreme enlargement of spleen and liver.

Comparing and contrasting otosclerosis, Gaucher's disease and osteitis deformans, the writer finds this in common, that their development depends on a disturbance of metabolism. In Gaucher's disease it concerns the cerebroside (cerasin), in osteitis deformans the calcium metabolism, in otosclerosis nothing that is definitely known. The petrous bone differs from other bones in that, owing to the early

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