SOCIETIES' PROCEEDINGS

ROYAL SOCIETY OF MEDICINE—SECTION OF OTOLOGY

May 5th, 1950

President—GAVIN YOUNG, M.C., F.R.F.P.S. (Glasgow).

OPENING PAPERS BY MR. F. MCGUCKIN AND MR. G. S. SEED APPEAR ON PP. 693 AND 700, AND THAT BY MR. A. TUMARKIN ON P. 611.

Discussion on Attic Suppuration

MR. R. SCOTT STEVENSON said that his approach to this subject would look rather old-fashioned. When he was looking at the literature in connection with attic suppuration he found himself relying more and more on Politzer and Milligan, and he still thought that they were good guides on the subject. He had the greatest admiration for Mr. McGuckin and Mr. Tumarkin, and when he contemplated the work of the latter he realized his enthusiasm, his energy, his disinterestedness and his skill, but he wondered all the time if, by any chance, he might be wrong.

He personally was very conservative about the ear. He hated doing radical mastoid operations, as did most otologists, and in regard to treatment in attic suppuration he was inclined to persist with local conservative measures. Most of these people had good hearing, and one did not want to do anything that could possibly affect their hearing. He was inclined therefore to persist with conservative treatment, removing, of course, granulations, small polypi and so on, and he used an attic cannula with the old-fashioned 50 per cent spirit or 5 per cent salicylic acid in spirit and also light liquid paraffin. He wondered whether some of these cases that they had seen today operated upon by Mr. Tumarkin and Mr. McGuckin, if such treatment had been persisted in, would not have got well without any operation whatever. Mr. Seed had pointed out the great difference between the house-surgeon or nurse doing treatment for the ear and doing it oneself, and, as Mr. Seed had said, in the war not only were otologists both consultants and house-surgeons but sometimes they were orderlies as well.

Persistent regular treatment would clear up a great many of these cases. If it did not clear up was it right to do what Mr. Tumarkin and Mr. McGuckin advised? Was it enough to approach from the front? He admired the skill of the technique, but was it a good thing to train the young otologist that that was the proper thing to do in suppuration in this potentially dangerous area?

When he himself found that simple treatment was not enough he carried out a very thorough cortical mastoid operation, exposing the aditus and the attic. He must admit that the last operation he did for attic suppuration was an ordinary radical mastoid, because the patient in addition was very deaf

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and had persistent vertigo and headache. In a case like that he thought it wiser to carry out a radical mastoid and be done with it.

He was always overwhelmed by beautiful technique but he wondered all the time whether the method shown that day was quite the right thing to teach the young otologist. Was there not some danger that the emphasis in his mind might be on technique as an end in itself? That was a very bad thing for the young otologist.

MR. E. WATSON-WILLIAMS said that he was very interested in this subject; but he could not help feeling that they had got rather beyond attic suppuration. Admittedly in many cases of chronic mastoid disease the attic was involved; but could they not concentrate their talks rather on those cases in which the disease involved only the attic and not the mastoid? Those seemed to be the cases which were marked out for special attention. He agreed that where one had disease of the mastoid, that is of the antrum, an operation, radical or modified radical, was necessary. But attic suppuration, both the acute and the chronic condition, was rather rare. He had been astonished when he looked up his own notes to discover that in 24 years there were only seven cases recorded in which disease confined to the attic had been treated by operation. In three of these there was a large cholesteatoma. He had been following up one patient for twenty years. This man had undergone a cholesteatomatous destruction of the bulk of the ossicles; he had lost the incus and the head of the malleus; yet the hearing was *normal.*

In this case and in others the antrum was not involved. Those were the cases which resolved with local measures, especially if one was rather persistent. Possibly this was the reason why he had found so few cases which actually came to operation. But he was quite certain that the real story was that these were cases in which the disease was confined to the attic. He could not prove it, but he believed that the initial acute attack cleared up in the whole of the middle-ear tract except in the space of Prussak, the almost isolated portion of mucous membrane behind the membrana flaccida. This suppuration might persist, cut off from the rest of the middle ear, and discharge occasionally a bead of pus. Those were the cases which yielded to conservative measures very frequently.

MR. T. A. CLARKE said that he wholly disagreed with Mr. Scott Stevenson when he advocated a wide Schwartze operation in attic disease; such an operation would merely lay open a healthy mastoid and do nothing to mitigate the disease in the attic. In discussing attic operations, one speaker had questioned whether the incus should be removed or retained; in his (Mr. Clarke's) view, once the attic had been opened it was always wise to remove the incus, which would otherwise remain a useless hindrance to healing.

MR. H. V. FORSTER said that he would like to support Mr. McGuckin in his call for the routine use of the magnifying speculum in our study of chronic middle-ear disorders.

The electrically-lighted otoscope and Siegle speculum were of great value and especially for the suction test, but a small Zeiss magnifier with a three-quarter diameter lens fitted loosely and immediately any size of speculum and when using the headlamp or the mirror according to the choice of the observer was an aid to speedy working, and through its aperture the fine aural probe

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could be conveniently passed for the testing of attic perforations and the separation of overlying crusts.

For those interested especially in the routine examination of children much experience would thus be gained of the insidious development of many cases of chronic suppurative otitis media and cholesteatosis and confirm some of us in our view that chronic otitis media was often chronic from the beginning.

He, Mr. Forster, believed that certain members would still prefer in their operations to expose the middle-ear cleft from behind the auricle. The soft tissues could be advanced further if the sheath of the temporal muscle were divided as Mr. Simson Hall had advised, and if one wished to leave the soft meatal tube attached to the tympanic ring tension could be relieved by dividing the tube in its posterior semi-circle just deep to the external meatus, an idea suggested to him in Continental writings supporting the retro-aural incision.

MR. I. SIMSON HALL said that he thought Mr. Tumarkin had remarked that the introduction of sulphonamides and antibiotics had rendered this subject of masked suppuration, as they might call it, all the more important. He had done them a great service by bringing this subject forward.

The young surgeon was rather apt to be biased by a complicated surgical procedure. In the case of a great many multiple stage fenestration operations he had the opportunity of examining the effect on the incus of having been moved at a previous operation and discovering whether it was detached, even slightly, from its original attachment. In a certain number of cases at least it had resumed its position sometimes by bony adhesion. That was a point which ought to be kept in mind in carrying out this delicate attic operation. If there was movement to any great extent the possibility was that the function of the incus would come to an end.

He had made a practice for a great many years of approaching the so-called sclerotic mastoid by post-auricular incision. There was no limitation, and should be no limitation, if properly treated, of the access to the bony structure if the post-auricular incision was done correctly. The temporal muscle sheath was much more easily split when it was lying exposed under the post-auricular incision than it was through the endaural incision which had been illustrated that morning.

Just one other point. Not long ago he was watching Julius Lempert of New York doing his work. When he came across one of these difficult mastoids he completely discarded his normal approach and did something quite different. To stereotype one's operations was a sign of stagnation, and for his own part, he felt a little perturbed if six months had gone by and he had done nothing to introduce some difference or modification in his own technique.

MR. J. J. BIBER said that some years ago he had the opportunity to observe a few instances of what he would like to call the self-healing of a cholesteatoma of the epitympanic recess of the antrum. In a case of cholesteatoma of the epitympanum, where the outer wall of the recess had been completely destroyed, he was able to remove mechanically all the masses with the result that a clean cavity appeared, including a defect in the upper and posterior meatal walls entirely similar to the outcome of an attico-antrotomy.

By this and similar experiences encouraged, he (Biber), ever since Lempert

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made the endaural approach popular, had favoured his method, and he was now following this method as the normal routine for chronic suppurations and cholesteatoma of the epitympanum in his work at the Battersea General Hospital. The reasons why he preferred this method were: (1) In most of these cases the process was confined to the epitympanum and antrum, and the pneumatization of the mastoid was very poor, so that there was no necessity to interfere with the mastoid at all; (2) the functional results were, as a rule, better; (3) the after-treatment was much shorter, and so was the time of the stay of the patient in hospital, and (4) the method recommended itself also for psychological reasons. Care should, however, be taken to remove enough of the bony wall of the antrum (the inner end of the posterior upper wall) so that the danger of the formation of adhesions in the cavity was checked. This result was also assisted by placing a flap sufficiently shortened and thinned right over the facial canal after it had been lowered down.

Mr. Donald Watson said that he would like all young surgeons to develop this fine technique. This was a definite advance. Knowing the men who had brought it forward, he was quite sure that they would not carry out this operation before trying adequate conservative treatment. He thought some of the speakers had forgotten that and he congratulated the openers on their new approach.

Mr. I. B. Thorburn said that he had a reputation in the north of England as an exponent of the Lempert technique. To him the main advantage of the endaural as compared to the permeatal approach was that it allowed room for instrumentation under the control of magnification by a binocular loupe. He felt that this enabled him better to appreciate and eradicate the pathology present in the middle ear, at the same time conserving any healthy and functionally useful structures.

He did not agree with Mr. Scott Stevenson's reference to the Tumarkin permeatal operation as a radical operation. He thought that all of them were able to clear up a proportion of cases of attic disease without operation, but in the resistant cases when a surgical measure was advised, the method described by Mr. Tumarkin should be regarded as a conservative operation for attic disease.

Mr. R. D. Owen said he would value Mr. Tumarkin's opinion regarding the treatment of those recurring cases of otitis media that frequently appear in a subacute form. The signs and symptoms are usually redness and fullness of the upper tympanic segment with a "gun metal" spread to the rest of the drum head below. The hearing loss is fairly persistent and pain is not a marked feature. Sometimes these cases when left alone turn up, sooner or later, with active chronic middle-ear disease and attic destruction.

One then realizes the possibility of having overlooked latent cholesteatosis with mild exacerbations. From the point of view of the prevention of deafness early interference seems advisable, but the problem is when to interfere and the method to be adopted while the drum head is still intact.

Mr. McGuckin, in reply, said that he no longer claimed to be following the Tumarkin technique, but had learned lessons of the greatest value before departing from it. Mr. Seed's description of the first two openers as ardent exponents of radical surgery was, perhaps, too radical a statement because

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it overlooked the fact that both speakers hoped to give greater consideration to conservation of function by earlier diagnosis and consequently by the employment of less radical surgery. Mr. Scott Stevenson's persistence in local conservative treatment might lead to a radical result merely from the lapse of time. In reply to the criticism that the discussion had become perhaps too wide, he personally had tried to stick to the terms of reference, with little mention of the technique of the Tumarkin procedure, an assessment of which had already been published. Whilst sympathizing with Mr. Clarke's view about the incus, he did not find himself in full agreement. Mr. Forster had mentioned a Polish professor who employed some kind of post-aural transmeatal technique, but it was hardly necessary to go to Poland since a description of such an operation was published in the *Journal* about a year ago. He agreed with what Mr. Simson Hall had said about the post-aural approach in that this did not prevent the operator from following a transmeatal or a transmastoid approach. However, the average meatus would in this event require some plastic procedure, so why not adopt an endaural technique from the start?

MR. TUMARKIN, in reply, said that he knew after that discussion what it felt like to be " damned with faint praise " and he was correspondingly grateful to Mr. Watson for defending him. He certainly did not operate until conservative treatment had been given a fair trial—but everyone knew how prone to relapse cholesteatosis could be. The attic variety was particularly treacherous in that respect—no doubt because of the associated necrosis of the incus.

In view of the conjoined threat both to hearing and life, the otologist who tolerated such a condition indefinitely was assuming a grave responsibility.

Mr. Scott Stevenson's claim that cortical mastoidectomy could deal adequately with attic disease was contrary to general experience and he was glad that Mr. Clarke so vigorously rejected it.

Conversely, the radical operation was far too drastic. Some speakers had questioned whether the permeatal approach could deal adequately with outlying disease. That was a standard criticism and was quite unfounded.

The surgeon could extend his incisions at will, approximating, if necessary, to the Lempert approach but in nearly a thousand cases, he had never resorted to that device.

Mr. Owen had asked what were the criteria for opening these relapsing ears.

He, himself, had come up to London to ask that very question. The whole problem of enclosed mastoiditis was obscure and he hoped that more of his colleagues would interest themselves in it.

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