# SOCIETIES' PROCEEDINGS

## ROYAL SOCIETY OF MEDICINE—SECTION OF OTOLOGY

**February 6th, 1942**

*President*—F. W. WATKYN-THOMAS, F.R.C.S.

### Discussion on Skin Diseases of the Ear

By REGINALD T. BRAIN

INFECTIONS of the external auditory meatus often produce secondary lesions in the path of the purulent discharge, and these lesions are unlikely to resolve until the otitis has cleared up. This is the task of the aural surgeon, and, because of anatomical factors, it is a difficult one, especially when œdema closes the meatal orifice.

*The pus-coccal infections.*—These are usually caused by streptococci and staphylococci, and clinically it is rarely possible to decide which organism is responsible. The pneumococcus may also give rise to similar lesions, and occasionally diphtheritic bacilli are recovered instead of the expected pus-cocci.

Impetigo contagiosa may affect the ear. The common scabbed type of sore is easily recognized but bullous lesions also occur in erythema multiforme and in those grave mysterious diseases of pemphigus and dermatitis herpetiformis. In hydroa æstivale, vesicular and bullous lesions erupt on the ears, face and hands during the summer, and unless it is noticed that the lesions affect all parts exposed to light, the ear eruption may be mistaken for impetigo. Circinate impetigo often resembles tinea, but its course is more rapid and its colour deeper red. Impetigo pityroides, the scaly variety, is similar to seborrhœic dermatitis. Ulcerative lesions are rare in impetigo, and cultures should be made to find the causative organism. The skin folds are commonly involved in impetigo, and retro-auricular intertrigo and septic fissures occurring under the lobule and in the fossa of the helix may be very resistant to treatment. From a moist lesion of impetigo, including intertrigo and fissures, a patchy pus-coccal dermatitis may spread to the face, neck or scalp. Treatment has a good deal to do with



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cause and prevention of this variety of dermatitis. Follicular infection from staphylococcal impetigo may result in a boil, but it is surprising how often boils arise as primary lesions. In the Near East cutaneous leishmaniasis produces a similar lesion but chronic in its course. Certain individuals are very prone to staphylococcal infections, and the seborrhœic subject is a well-known dermatological type. Plump and placid or thin and nervous, the seborrhœic subject has a moist greasy skin, a liking for carbohydrate and fat, and a marked susceptibility of the skin and mucous membranes. Apparently the skin is attacked by the pityrosporon of Malassez, the benign bacillus abundantly found in scurf, for it is certain that many a scurfy scalp becomes inflamed and a scaly dermatitis spreads from it to the ears, face, and neck ; also to the mid-line of the back and chest and to the folds and flexural surfaces. A retro-auricular intertrigo of seborrhœic origin is very common and is easy to recognize if the pale pink lesions covered by a flaky, soft, greasy scale are seen to be continuous with the scalp condition. Pus-coccal intertrigo has a deeper colour, and when it spreads into the scalp it does so asymmetrically, and the unaffected parts are not scurfy. The seborrhœic lesions invade the auricle and external meatus and, if they are a part of the condition described above, the diagnosis is not in doubt. This suggests that seborrhœic dermatitis is a specific infection, but unfortunately the pathogenicity of the pityrosporon has not been established, and the scaly lesions of impetigo suggest that mild coccal infections produce similar lesions, so that seborrhœic dermatitis is still a controversial subject for dermatologists. So is eczema which is obtusely confused with dermatitis.

Dermatitis is surely an inflammation of the skin, having a cause and classical signs and symptoms. If the cause is removed the inflammation should subside. Frequent examples are met during the treatment of coccal and seborrhœic lesions when some application irritates the skin. The affected area becomes erythematous and œdematous, and burns, and the exudate causing the œdema may raise vesicles or blebs or ooze through the horny layer and make a moist surface. If this dermatitis venenata is recognized early and the causative irritant removed, the inflamed skin will soon respond to cooling lotions.

Eczema is a reaction peculiar to a hypersensitive skin, and the hypersensitivity can be inherited or acquired. In varying degrees most irritants can sensitize the skin, and if the eczematous reaction occurs while the skin is inflamed the eruption appears on an area of dermatitis which is then described as eczematous. The first essential feature of eczema is that when the cutaneous hypersensitivity has been established the eruptions are often independent of external factors, or at least the irritating properties of those



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factors are imperceptible to the normal skin. The second essential feature is the morphology of the lesions. Eczema appears as grouped, minute papulo-vesicles set in non-inflamed skin. The vesicular character, microscopically constant, becomes obvious when slight scratching reveals a weeping spot. Itching is marked in the eruptive phase but subsides when weeping begins. The exudate dries into golden crusts or maintains a moist surface upon which the skin cocci flourish and produce a dermatitis sometimes obscuring the eczema. Since eczema is the reaction of a hypersensitive skin the appearance of the eruption is the call to suspend the use of active remedies and to apply bland lotions and emollients. General treatment with sedatives to allay irritation and to restrain scratching is important, and calcium and vitamins help to reduce the reactivity and permeability of the skin capillaries. Ultraviolet light has a good effect upon the skin, upon metabolism and upon the mental outlook of the patient.

The chronic infections of tuberculosis, syphilis, leprosy, yaws and leishmaniasis may attack the ear, and the granulomatous eruptions due to bromide or iodide are somewhat similar in appearance to the lesions of these infections.

Lupus vulgaris more commonly affects the face than the ear, and can be recognized by its brownish-red translucent nodules which have a close resemblance to apple jelly when compressed under glass. This may be difficult to observe in the lobule, which often becomes reddened with congestion. Lupus vulgaris is an active tuberculosis of the skin leading to ulceration, and the lobule and a considerable part of the pinna may be destroyed. It also occurs in the purple congested lobules of patients with chilblains, and is then called lupus pernio. The sarcoid of Boeck shows similar lesions, and nodular infiltrations of the skin also occur in leukæmia and in Hodgkin's disease.

Lupus erythematosus is quite distinct from lupus vulgaris but its final atrophic phase results in just as much destruction of the pinna but without ulceration. The erythematous lesions are superficial and scaly and horny plugs mark the orifices of the sebaceous follicles. It is thought that lupus erythematosus is an allergic reaction to streptococcal or tuberculous infection and certainly the most dramatic cures result from the extirpation of a septic focus, usually found in the nose or throat. When a focus cannot be found, treatment with sulphanilamide or sulphapyridine gives a fair measure of success and some support to the view that the streptococcus is of ætiological importance.

Mycotic infections of the ear are rare and it is not proposed to discuss them. When they do occur perhaps the experience of the dermatologist with the common fungus diseases would be of value to the otologist.



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The virus lesions of the skin are also rare, but they are not without interest. Herpes simplex and zoster are often confused and indeed if the eruptions are scanty it may be impossible to distinguish between them. Both have an eruption of grouped vesicles on an inflamed base and are unilateral. Zoster is the more painful and its eruption is often spread over the distribution of the cutaneous sensory nerves belonging to the ganglion attacked. The pinna is mainly involved with the adjacent parts of the face and neck when zoster attacks the second and third cervical ganglia and the extent of the eruption makes the diagnosis clear. Of greater interest and difficulty is zoster of the geniculate ganglion, for the sensory supply of the VIIth nerve is somewhat rudimentary and overlaps that of adjacent nerves to the tympanic membrane, the external auditory meatus and the adjacent parts of the concha, so that a few vesicles in these inconspicuous sites or on the anterior part of the tongue may be the only direct evidence of zoster infection as the cause of facial palsy. In 1907 Ramsay Hunt[1] drew attention to these facts in his classical paper on " Herpetic Inflammations of the Geniculate Ganglion " and in 1933 Aitken and I[2] were able to confirm Ramsay Hunt's thesis by using a method of complement fixation for zoster which I had found to be reliable[3]. The sera of 9 cases of Bell's palsy with zoster-like eruptions in the areas of the sensory supply of the geniculate ganglion were all found to contain antibodies to zoster virus while the sera of 22 cases of Bell's palsy without such eruptions had demonstrable antibodies to zoster in only four instances, or in less than 20 per cent. Since evidence exists to support the view that symptomatic zoster, and herpes, are the result of the activation of latent virus by infection, trauma or shock, it is possible that the unexpected post-operative Bell's palsy is a zoster lesion even in the absence of a vesicular eruption. The possibility would be a probability if, after a few weeks, the presence of zoster antibodies could be demonstrated in the patient's serum. With good antigens the complement-fixation test for zoster is as reliable as the Wassermann reaction, but the test is rarely used outside a virus research laboratory.

Zoster should not be confused with herpes simplex. Zoster virus is probably a modified strain of varicella virus. Immunity after infection is usually solid and lasting, so that zoster rarely recurs. It is non-infective for the ordinary laboratory animals. On the other hand herpes is not related to zoster. Recurrent attacks are common and the rabbit and guinea-pig are readily infected.

Warts and molluscum contagiosum may occur on the ear and their virus origin should be remembered because cure necessitates the destruction of every infected cell. The virus lesions of variola, varicella and vaccinia may be seen on the pinna and bromides and



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iodides produce good imitations of these lesions. The rare condition of painful nodular growth of the ear is of obscure ætiology but its pathology is that of focal inflammation with necrosis of cartilage and a foreign body reaction, the epidermis being thickened above it. This chronic painful nodule develops upon the upper part of the helix and often makes the pressure of a hat or pillow unbearable. It will respond to some method of cauterization but rarely to other treatment.

The keratoses are interesting dermatological lesions and some varieties remain as obscure to dermatologists as keratosis obturans does to the otologists. Hyperkeratosis occurs in certain congenital abnormalities such as ichthyosis. It may be a functional disorder and is quite common after any severe erythema, whether that is due to local irritation or to infection, toxins or drugs. It is characteristic of seborrhœic dermatitis, psoriasis, pityriasis rubra and follicular lesions such as keratosis follicularis and keratosis pilaris. The latter condition and possibly some of the diffuse keratoses may be manifestations of vitamin A deficiency.

Senile keratoses are not uncommon on the helix and may be recognized as horny wart-like papules. Removal of the horny cap reveals a bleeding shallow crater with the raised and irregular features of an epithelioma. The histology is suggestive of a pre-cancerous lesion in the early phase and eventually most senile keratoses develop into squamous-celled epitheliomata. Tar warts and actinic keratoses have a similar pathology and all these keratoses should be treated with radium or failing that, be destroyed by some form of cautery. In the congenital disease of xerodermia pigmentosa young subjects are very sensitive to sunlight and in consequence rapidly develop freckles, atrophic macules and actinic keratoses which become malignant. The natural prominence of the pinna exposes it to sunlight so that it is a common site for actinic lesions.

Rodent ulcers and the primary type of squamous-celled epitheliomata occur on the ear and, since invasion of the cartilage is almost inevitable, the prognosis is not so good as when the lesion is solely dermal, and disfigurement is common. Moreover cartilage reacts badly to irradiation, and a very painful necrosis with perforation sometimes follows.

*Dermatological principles of treatment.*—Treatment should be governed by two important facts. The first is that our protection from external irritants and infections depends upon a dry and intact horny layer, and treatment should be designed to maintain it. Pyogenic lesions are often spread by wet dressings or by ointments which retain sweat and exudates. The second fact of therapeutic importance is that living cells are instantly damaged by water or by grossly hypotonic solutions, and this applies to the



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skin when the protective stratum corneum is missing or its continuity is disrupted by exudation. Thus the washing of a weeping eczematous area with plain water is usually quickly followed by an increase of the irritation, erythema and exudation, and in consequence resort is made to the inferior procedure of cleansing with oil instead of trying isotonic solutions.

Before considering local applications in detail, thought should be given to the general condition of the patient and his or her reaction to the skin lesion. Eczema and lichen simplex are often manifestations of a neurosis and many a pus-coccal infection fails to clear up with proper treatment because the patient scratches. Reassurance and small doses of phenobarbitone makes the difference between success and failure in such a case. Although it is obviously sensible to consider the patient's diet and to advise the use of protective foods, dermatologists have found few indications for rigid dieting. It would also appear that too much has been expected of the vitamins. Vitamins A has been used hopefully in the keratoses; vitamin $B_1$ for neurogenic and herpetiform lesions; vitamin C in the infections and to protect the capillaries; vitamin D for its effect upon calcium metabolism and so diminishing the irritability of, and the exudation from, capillary vessels; and nicotinic acid for its influence in desensitizing the skin to sunlight, and possibly as a factor in the resistance of nerve tissues to herpetic infections. Sulphonamide is very valuable when a pus-coccal lesion of the skin shows its virulence by a bright erythematous flare.

In the chronic stayphylococcal infections small doses of thyroid and injections of collosal manganese or of manganese butyrate appear to be beneficial. Toxoid and vaccine constitute more rational therapy but often fail because the general immunity they undoubtedly confer does not influence the carrier state nor the susceptibility of the skin to the staphylococcus.

*Therapeutic agents in dermatology.*—Of these, lotions are the most useful. Calamine lotion is well tolerated even by the eczematous skin and the addition of 2 per cent. phenol or 0·1 per cent. mercury perchloride gives it antiseptic qualities. To allay irritation 2 per cent. of tar solution or of strong solution of lead subacetate may be added and for seborrhœic dermatitis 2 per cent. of precipitated sulphur. A lotion with a powder basis adds to the debris of the meatus and this can be avoided by using simple solutions. Gentian violet, methyl violet, brilliant green or malachite green can be used in 1 or 2 per cent. solution in water. Acriflavine 0·1 per cent. in water has the advantage of not obscuring the skin lesion, and for exudative conditions 4 per cent. of tannic acid may be added. This lotion is useful for moist pus-coccal lesions and for eczema. The metallic slats are used when an astringent effect



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is indicated ; they are antiseptics too but of a low order in the presence of exudate ; they have little power of penetration unless ionized and idiosyncrasy towards them is not uncommon. Examples are : mercury perchloride 0·1 per cent. ; l'eau d'Alibour which consists of zinc sulphate 6 gr., copper sulphate 4 gr., and camphor water to one ounce ; silver nitrate 1-5 per cent. in distilled water is also useful.

When a quickly drying application is indicated a spirituous paint should be used. For example, the aniline dyes already mentioned can be dissolved in 50 per cent. industrial methylated spirit or 10 gr. of silver nitrate can be dissolved in 60 minims of distilled water and made up to one ounce with spirit of nitrous ether. Eczematous lesions are very intolerant of spirit which is painful unless the horny layer is intact but spirit paints penetrate the follicles better than watery lotions and are useful to localize boils.

A 5 per cent. sulphanilamide solution in glycerin is a useful paint for crusted pus-coccal lesion and as a dressing for septic ulcers. Powders are used to dry up exudates and to limit infections of the skin, and powdered sulphanilamide is certain to prove of value in the treatment of meatal lesions. Bismuth subgallate is another useful astringent powder and 5 per cent. of calomel may be added to it as an antiseptic or added to a zinc oxide and talc basis.

When lotions are not tolerated or when the skin becomes too dry and tends to crack, creams or pastes are indicated.

The simplest cream consists of equal parts of a vegetable oil and lime water with perhaps 5-12 per cent. of hydrous lanolin to make it more stable. 5 or 10 per cent. of zinc oxide or calamine added to this emulsion makes a zinc or calamine cream which may be medicated with 2 per cent. each of phenol, tar solution, ichthyol or sulphur ; the latter being of service in seborrhœic dermatitis. A paste should contain equal parts of powder and grease ; for example zinc paste consists of starch 25 per cent., zinc oxide 25 per cent. and vaseline 50 per cent and to this may be added 2 per cent. of salicylic acid, or 3 per cent. of coal tar or of yellow oxide of mercury and similar percentages of ichthammol, resorcin or sulphur are used for seborrhœic lesions. Pastes with their high content of powder can absorb water and lose it, so that the skin surface is drier and cooler than when it is covered by ointment. Besides this therapeutic gain the saving of 50 per cent. of the fatty base is a valuable economy in war.

Ointments are made with bases of vegetable and animal fats with the addition of hard and soft paraffin or of the latter alone as a base. Recent advances have been made with new emulsifying bases which are less greasy and bring the active ingredients into more intimate contact with the tissues. These new bases are



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readily miscible with water and so are much more easily cleansed from the skin. Comment has been made upon the limited use of ointments in dermatology, and no reference need be made to those in common use. Ointments containing sulphanilamide are certainly potent on streptococcal lesions of the skin and quinolor ointment is often very effective on staphylococcal lesions. So little of these ointments is required for an individual patient that there can be no objection to using a proprietary preparation.

Since seborrhœic lesions of the ear usually resist treatment or soon recur unless the scurfy condition of the scalp is cleared up, here are a few hints on the treatment of the scalp. For a dry scurfy scalp an ointment of 3 per cent. precipitated sulphur and salicylic acid should be rubbed in at night and shampooed out after a day or two with sulphur soap and weak sodium carbonate solution. Instead of the ointment a liniment of salicylic acid 25 gr., industrial methylated spirit 1 drachm and castor oil to one ounce may be preferred. 5 per cent. of phenol or of liquor picis carbonis may be added to the ointment or to the liniment to allay irritation. When the scurf has been cleared relapse may be prevented by the continued use of a lotion such as: resorcin 10 gr., industrial methylated spirit 2 drachms and liquor hydrarg. perchlor. to one ounce. If this proves to be too drying 20 minims of castor oil or of glycerin should be added to each ounce. Weekly shampoos are indicated in subjects prone to pityriasis capitis or seborrhœa.

*Physiotherapy.*—Otologists are familiar with methods of ionization and are no doubt aware that although the penetration of ions is slight the surface effect of the solutions employed is greatly intensified. In consequence eczematous lesions are usually aggravated by ionization. Although lesions of the meatus can be treated with local ultra-violet light by quartz applicators and a Kromayer lamp the greater beneficial effect of general ultra-violet ray therapy in chronic infections is often unsought. It is not generally realized that a drying source of heat is most comfortable and healing in the treatment of boils, and use should be made of infra-red rays, diathermy or X-rays. The last-mentioned in fractional doses is of the greatest service in many chronic skin diseases of the ear and it is unnecessary and less effective to attempt to restrict the irradiation to the meatal walls. Radium and radon are invaluable agents in the treatment of the senile and actinic keratoses and of the epitheliomata.

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The PRESIDENT asked, with regard to allergic reactions, could a patient become sensitized to preparations commonly employed? He had noticed that a patient would do well for a time on one particular preparation and then suddenly get worse. Was that true of mercury and sulphur?

The abuse of peroxide was responsible for many of their troubles. Patients with discharge were too often sent away, week after week, with peroxide drops. Could peroxide set up a chronic dermatitis?

As to zoster lesions, the complement-fixation test should establish the diagnosis in doubtful cases of Bell's palsy between the true palsy *a frigore* and a missed zoster.

Lastly, in keratosis obturans. Was this a true keratosis or was it a cholesteatoma which had burst its way through and so dilated the cavity?

Mr. R. J. CANN said that he had occasionally met a condition which he had not seen described. The patient complained of a chronic discharge, with possibly a history of bleeding, and after cleaning out the meatus there was seen on the deepest part of the walls of the meatus or even on the membrane, patches of granulation which bled when touched. Apart from the granulations the membrane was seen to be intact. One or two applications of a caustic to each of the granulations would clear the condition up in a week or a fortnight. He did not know the pathology.

Dr. HUGO FREY said that he was glad to hear Dr. Brain attribute importance to the mental condition of the patient because he had also come to the conclusion that in a number of cases eczema or dermatitis was only secondary to itching sensations of nervous or psychic origin. Itching in the meatus was very common. It was known that the Chinese were accustomed to carry about with them a small instrument for the purpose of scratching their ears.

Another reason for the eczema was possibly an over-indulgence in personal cleanliness. There was a general idea that the meatus must be most thoroughly washed, and he had seen even nurses and mothers continually trying to cleanse babies' ears, and this was frequently the cause of eczema. The complete removal of cerumen might make the skin of the meatus too dry, and so produce the itching. Many ointments and oily compositions were dangerous and likely to make an existing eczema even worse.

For local treatment in acute cases resorcin solution 1-2 per cent. seemed to be very efficient.

Mr. F. C. ORMEROD said that amongst civilians the most frequent type of external ear disease was an ezcematous condition associated with seborrhœic dermatitis.

There were, after the last war, many soldiers and other service men who required treatment for a chronic thickening of the skin



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of the meatus. The meatus was found to be almost impervious to anything but a small probe. It was assumed that most of these men had chronic middle-ear suppuration, although in many cases the drum head was never seen.

During the last two years he had seen many young soldiers with a similar condition in a much earlier and more acute state. He did not think the condition was one of seborrhœic dermatitis, but most of them had infection of the tonsils. They often required several weeks of treatment. He felt that there must be many more people in the Forces with conditions of this kind, and that there was great danger of chronic external otitis resulting under Army conditions. It would be interesting to learn whether the members in the medical services were having much trouble from this external otitis.

Lieut.-Colonel M. L. FORMBY said these cases caused much trouble in the Army. Difficulties had arisen firstly from 1937 onwards men were accepted into the Army with discharging ears, and secondly when civilian medical boards were introduced in 1939 no instructions were issued regarding otitis externa. In future chronic cases would not be admitted. The present problem was the large number already in, many of whom had now become extremely useful soldiers. If possible these men must be retained. Many lost a great deal of time attending sick parades and having treatment, others spent a considerable time in hospital. The aim now was to investigate the cases in the Army, co-operating with dermatologists, in an endeavour to ascertain their nature, whether seborrhœa, eczema, etc., and to treat on appropriate lines. From now on instructions to civilian medical boards would be that these cases should be sent for an otologist's opinion before they were accepted.

Men in the Army with chronic otitis externa for which no definite cause could be found and in whom treatment was unsucessful would be boarded out unless they were extremely useful persons whom it was desirable to retain.

One Army otologist had taken a great interest in otitis externa and had been struck by its association with dental trouble, particularly impacted wisdom teeth. He had been encouraged to collect these cases and publish findings.

Dr. Agnes Savill mentioned the case of a man who had suffered for four years with a condition of infective eczematoid dermatitis of the ears, with blocked auditory canal and much œdematous swelling of the whole ear. Ionization given deep down into the canal with zinc, and then salicylic acid, had effected a cure in about six weeks.

A simple remedy for dandruff of the scalp consisted of half to one dram of liq. carbonis detergens to the ounce of water.



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Lieut.-Colonel MITCHELL-HEGGS supported Dr. Brain and others in their views on the importance of the treatment of septic foci in certain cases and the value of post-operative rest and adequate diet, especially for those patients who relapsed after apparent recovery following an effective local application such as that of a weak silver nitrate lotion. He mentioned the importance of bacteriological examination and recalled a case of *B. pyocyaneus* infection of the meatus successfully treated by Major Philip Scott. He also recalled a case of recurrent pruritus and dermatitis which responded well to general treatment for gout, and stressed the importance of keeping hair away from the pinna and avoiding hats which compress the ears in women suffering from active or convalescent dermatitis of the pinna with a sensitive ticklish skin.

Mr. W. STIRK ADAMS said that he also had seen the granulations on the drumhead associated with a discharge; he had regarded it as a secondary condition, but he agreed with Mr. Cann. As to chronic otitis externa affecting the deep meatus, it was a difficult condition, and the most successful treatment was 5 per cent. silver nitrate in aqueous solution. The patient was also asked to use 2 per cent. nitrate of silver drops daily for about a fortnight, and after that to keep it by for use at longer intervals. Generally the condition cleared up after two or three weeks' treatment.

Mr. R. D. OWEN asked Dr. Brain for his opinion as to the use of the "wet" or the "dry" treatment in patients with chronic eczematous meatitis; in other words the use of drops as compared with powders.

Dr. REGINALD T. BRAIN in reply said that the skin could be sensitized by simple chemical substances but this was not common with the preparations usually employed. Mercury and sulphur were irritants and dermatitis was often seen after their use. He had never seen a case of dermatitis which could be attributed to hydrogen peroxide but cases had been reported by Sabouraud. Probably the continual wetting was the main factor but the protective horny layer would undoubtedly suffer mechanically and by oxidation from peroxide.

He was in entire agreement with Dr. Frey's remarks and several types of prurigo were recognized by dermatologists in which the skin lesions, usually eczema or lichen simplex, were the result of scratching. A common site for this neurogenic lichen was just behind one ear.

With regard to the "wet" or "dry" treatment of chronic eczematous meatitis the continued and casual use of ear-drops by a patient was bad for the skin. An œdematous skin was usually aggravated by moisture and in dermatological practice drying lotions and paints would be used. Since the meatus was badly ventilated it must be carefully dried by expert swabbing or by a



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warm jet of air. Powders might be useful in the terminal phase but they formed concretions with exudate; an obvious disadvantage. In conclusion Dr. Brain paid tribute to his teacher, Dr. J. H. Sequeria and to Professor S. P. Bedson for help in researches upon virus diseases of the skin.

## REVIEW OF BOOK

*Victorian Doctor: the Life of Sir William Wilde.* T. G. WILSON. (Methuen, London, 1942.) Pp. 330, with 61 illustrations and frontispiece. Price 15s.

To the otologist the name of Sir William Wilde suggests an aural snare, a method of treating mastoiditis (Wilde's incision) and a book on *Aural Surgery* which, though published in 1853, is still well worth reading. Others there are who regard Sir William Wilde simply as the father of Oscar Wilde, while it is also generally known that both father and son, in their later years, faced scandal and degradation in Courts of Law.

Now Dr. T. G. Wilson, a Dublin otologist and a writer of no small literary merit, has assumed the task of revealing Sir William Wilde in a truer light. Without unduly minimizing his faults, the author has depicted Wilde as archæologist, as census commissioner, as medical editor, and as hospital administrator.

Archæology was the science which lay nearest to his heart. This interest was awakened and stimulated by a voyage to Madeira, Egypt and Palestine as personal medical attendant to the owner of the steam yacht "Crusader". On his return, still only twenty-five years of age, Wilde published a narrative of his travels which was an immediate success. Even more popular was his description of *The Beauties of the Boyne and Blackwater* which appeared ten years later. Another contribution to archæology and scenery of Ireland was his work on *Lough Corrib*, but the crowning achievement was his *Catalogue of Irish Archæology*, prepared for the Meeting of the British Association in Dublin in 1857.

He must have been a man of tireless energy, as we learn that, although engaged in a busy specialist practice, he accepted the appointment of Medical Census Commissioner and conducted the intricate statistical duties with such skill as to earn for himself the honour of knighthood.



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