SOCIETIES' PROCEEDINGS

AUSTRIAN OTOLOGICAL SOCIETY

Meeting November 28th, 1932

Abstracted from the Monatsschrift für Ohrenheilkunde, February, 1933.

By A. R. TWEEDIE

CASES

Central Speech Deafness, with partial retention of tuning fork perception, and loss of vestibular function, due to Encephalitis.—E. URBANTSCHITSCH.

A man, aged 44, who had suffered from dysentery and malaria during the War, shortly after the termination of same, succumbed to attacks of vomiting, severe headache, giddiness and, latterly, had become completely deaf. His vision was normal up till recently. The effect of alcohol and tobacco could be excluded.

Examination—Ears.—Objectively, normal on both sides. Functional tests, complete deafness to conversation on each side. Certain strongly vibrating tuning forks, however, were definitely recognised by each ear, but no perception for bone conduction on either side could be elicited. Romberg, positive. Tendency to fall to the left. On rotation in either direction, only four nystagmus movements could be elicited, with associated by-pointing. Caloric reaction each side, negative. Wassermann reaction negative. Examination of ocular fundi showed post-neuritic atrophy, more marked on the left side than the right, whilst the vision on the left side was markedly affected.

Neurological report.—Encephalitis in the region of the posterior cranial fossa.

The Exhibitor remarked that although it was certainly a case of encephalitis, no suggestion as to its exact ætiology could be offered.

The effect of weakness of the Sixth Nerve in the rotation tests and its occurrence after Labyrinthitis.—E. RUTTIN.

A man, aged 30, was admitted to Hospital on *September 26th*, 1932. Since 1924 he had suffered from an occasional left otorrhœa, with tinnitus, headache, giddiness and pain during periods when the

https://doi.org/10.1017/S0022215100039396 Published online by Cambridge University Press

discharge ceased. Since *May*, 1932, no otorrhœa had occurred and he therefore asked for examination, as he was alarmed at its cessation, although he then had no particular symptoms. On examination the right ear was normal, but on the left side there was a large defect of the outer attic wall in which, however, no active disturbance or cholesteatoma could be seen.

Hearing.—Left, conversation at 1 metre. Whisper *ad concham.* Rinne, negative. Bone conduction increased. C.1. c^4 shortened. Weber not lateralised. Fistula symptom positive, but compression caused only a slow movement to the right, and aspiration only a slow movement to the left.

Rotation (head erect) nystagmus to the right and left respectively, lasting 10 seconds, but after rotation to the left, the right eye always moved back to the middle line. (Fatigue of the right sixth nerve.)

Rotation to right and left (face down) resulted in corresponding rotatory nystagmus to left and right, lasting 6 seconds, but with a similar indication of fatigue of the right sixth nerve after rotation to the left.

Rotation to the right (head on the right shoulder) induced nystagmus downwards which lasted seven seconds. Rotation to the right (with head on the left shoulder) induced nystagmus upwards, lasting 5 seconds, both of which latter tests were associated with marked giddiness and body movements.

Wassermann, negative.

X-ray examination of left mastoid. Cells scanty and hazy. Antrum obviously enlarged. Boundaries indefinite. Sinus plate intact. Tegmen suggests commencing atrophy. Physician's and oculist's examination reveal no abnormality.

October 18th, 1932.—Operation.

Cholesteatoma occupying antrum and attic loosely. Posterior meatal wall removed. Fistula in horizontal canal. Incus not present but membrane and malleus intact and therefore left undisturbed. Wound left open.

Convalescence was normal and by *October 26th* no trace of weakness of the sixth nerve could be noted, although the fistula symptom was still present. The retro-auricular wound was healed by *November 23rd*, when loud speech could be heard. Weber was lateralised to the right. Fistula symptom was still present but very weak and was elicited only on compression, but response to rotation was asymmetrical as follows:

Head erect. Rotation to the right, nystagmus to the left, 1 minute, 5 seconds.

Rotation to the left, nystagmus to the right, 14 seconds. (Weakness of R. 6th nerve.)

https://doi.org/10.1017/S0022215100039396 Published online by Cambridge University Press

Face downwards. Rotation to the right, nystagmus to the left, 4 seconds.

Rotation to the left, rotation to the right, seven seconds.

Head on Rt. shoulder. Rotation to the right. Downward nystagmus, 6 seconds.

Lt. shoulder. Rotation to the right. Upward nystagmus, 5 seconds.

The exhibitor remarked that some years ago he had shown that quite a slight 6th paresis, which would escape even the notice of the oculist on cursory examination, could be demonstrated by rotatory reaction, that is to say that after rotation towards the side of the affected 6th nerve, the eye movements always became fatigued and the eye-ball tended to move back continuously into the middle line.

In this case the 6th paresis was not really referable to the aural disease, but was the result of a subsequent serous labyrinthitis which had occurred. At the present time, the phenomenon could not be demonstrated in this case.

Traumatic Parotid Fistula.—E. GRABSCHEID.

A patient was shown, who had already been shown at the previous Meeting, in whom, as the result of a wound, a fistula of the parotid had occurred behind the ear. The fistula was closed by diathermy with an immediate and excellent result. Three months ago, however, sudden recurrence of secretion had occurred, followed in twenty-four hours by the discharge of a piece of wood, 3 cm. long and ½ cm. broad, which had not been detected previously by any form of palpation.

Chronic Suppurative Otitis Media Left, with Polypus and Temporal Lobe Abscess. Operation. Recovery.

—W. STUPCKA.

An old man was admitted to Hospital on *December 21st*, 1931, with the history that in spite of a retro-auricular operation on the left ear eleven years ago, he still suffered from a purulent discharge. Lately he had considerable pain in the ear and head, but no giddiness or vomiting.

Examination.—Right ear. Membrane grey, opaque.

Left ear. Large irregular post-aural scar soundly healed. Meatus occupied with pus and polypoid granulations preventing accurate view of the fundus.

Nose and Throat. n.a.d.

Hearing.—Right, whisper at 1 metre.

Left, whisper nil but slight appreciation for tuning forks a^1 and c^2. Weber to the right.

https://doi.org/10.1017/S0022215100039396 Published online by Cambridge University Press

Cold Caloric Test.—Left, gave normal reaction. No fistula symptoms.

Diagnosis.—Chronic middle-ear suppuration left, with retained cochlear and vestibular function.

24.12.31.—Radical operation.

Large destruction of lower portion of mastoid process. The antrum was large, and both it and the aditus and middle ear were occupied with cholesteatoma. There was in addition a localised area of granulation in the posterior wall of the antrum, and on removing the underlying affected bone, a fistula was revealed, from which thick yellow offensive pus issued. Further exploration showed that this led into a temporo-sphenoidal abscess for the adequate exposure of which, removal of the posterior portion of the labyrinth was necessary. The abscess cavity was drained with gauze and the wound left open.

After an uneventful convalescence a plastic operation was undertaken for closure of the wound on *January 30th*, 1932, but owing to further suppurative conditions, considerable local treatment was entailed and this local condition combined with total loss of cochlear function and lack of vestibular response, indicated the probability of a sequestrum in the region of the labyrinth—a view which was supported by further X-ray examination.

Accordingly, on *May* 18th, 1932, an operation was undertaken, when two sequestra of the labyrinth were removed, after which, except for a transient facial paresis, further convalescence was uneventful and the patient was discharged in *July*, 1932.

Contribution to Disease of the Otoliths.—E. RUTTIN.

A woman, aged 45, who had been perfectly well previously except for severe headaches (for which she had taken a mixed powder containing phenacetin, antipyrin, codeine and caffeine), had a sudden attack of giddiness in *March*, 1932. The details of this giddiness she could not report but it was associated with vomiting, and the attack lasted about a quarter of an hour, and was relieved, as she stated, when she had found a position in which she could lie comfortably. Whilst on her back there was no giddiness, but this occurred directly she lay on her right side.

She was admitted to the Medical Wards for fourteen days and was then discharged with the report that all examinations, including the Wassermann reaction, were negative.

On *October 26th* she had another attack of giddiness which was worse on lying down, and better whilst sitting, associated with vomiting but no tinnitus and it was on this occasion that the Speaker first saw her.

Examination.—Tympanic membranes and hearing normal R. and L. No spontaneous nystagmus, no by-pointing.

https://doi.org/10.1017/S0022215100039396 Published online by Cambridge University Press

On lying on the back, a rotatory nystagmus to the right lasting 1 minute appeared and, if she turned on to the left side, only a very slight rotatory nystagmus to the right could then be seen.

If from the sitting position she lay on her back, a rotatory nystagmus to the right occurred, lasting a minute and with marked giddiness.

If when lying on her back she turned her *head* to the left, then no nystagmus or giddiness supervened.

If when lying on her back she turned her head to the right, then nystagmus for one minute to the right occurred with marked giddiness.

In the prone position there was no giddiness and no nystagmus, but if in the prone position the head was turned to the left, then a rotatory nystagmus to the left lasting one minute occurred with marked giddiness, whereas if, in the same position, the head was turned to the right, then no nystagmus or giddiness occurred.

Rotation Tests :—

Head erect. Rotation to the right, induced nystagmus to the left, 4 seconds, with giddiness.

Rotation to the left, induced nystagmus to the right, 15 seconds, with giddiness.

Face downwards. Rotation to the right, induced rotatory nystagmus to the left, 4 seconds, and marked giddiness with falling to the right.

Rotation to the left, induced rotatory nystagmus to the right, 9 seconds. Marked giddiness with falling to the left.

Head on Rt. shoulder. Rotation to the right, downward nystagmus, 7 seconds. Marked giddiness, falling backwards.

Lt. shoulder. Rotation to the right, upward nystagmus, 5 seconds. Marked giddiness, falling forwards.

Caloric reaction applied to right ear, after 45 seconds, nystagmus lasting 60 seconds, with giddiness and typical by-pointing.

Applied to the left ear, after 30 seconds, nystagmus lasting 75 seconds, giddiness and typical by-pointing.

The Author suggested that the patient exhibited the typical symptoms of a lesion of the otoliths, as has been described by Voss, and that the result of the rotation tests indicated a lesion on the left side, and that this lesion was probably referable to the toxic effects of the powder which the patient had been in the habit of taking for many years past.

The case also corresponded with many other instances which he himself had described.

https://doi.org/10.1017/S0022215100039396 Published online by Cambridge University Press