SOCIETIES' PROCEEDINGS

AUSTRIAN OTOLOGICAL SOCIETY

Meeting November, 1932

Abstract of Proceedings

By A. R. TWEEDIE

CASES

Two cases of persistent auricular fistula following antrotomy.—H. NEUMANN.

The cases were shown, not with a view to considering the further plastic operation required, but to raise a discussion on the genesis of this occurrence. The first case was that of a boy, 10 years old, who was operated on on both sides in America for acute mastoiditis. Whilst the wound was completely and normally healed on the right side, on the left there remained a fistula leading into the antrum. The middle ear was dry on both sides. The Radiologist gave the following report:

Defect after antrotomy, surrounding which numerous small slightly hazy cells were still to be seen. The sinus appeared in its normal position and presumably was not exposed at the operation. With the exception of minor unimportant details, the pictures were alike on both sides.

The second case was that of a boy, aged 6 years, who, during the previous winter, was operated on, on both sides for the relief of otitis media of short duration. Since the secretion on the right side did not cease, and as there was a persistent retro-auricular fistula on both sides, the parents requested a plastic operation.

It would be seen that there was now a profuse discharge in the post-auricular wound on each side and, whilst the left meatus was completely stenosed, the right was normal in calibre and dry. The Radiologist reported:—

Right.—Defect after an apparently fairly extensive antrotomy. The defect is surrounded by hazy cells, most evident in the area of the posterior meatal wall and root of the zygoma.

Left.—Defect after antrotomy. *Bordering* the antrum there is a large group of cells to be seen posteriorly, over the root of the zygoma and towards the apex.

In the first case, the Exhibitor had already closed the unilateral fistula by plastic operation.

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In the second case, for various reasons, no operation had yet been undertaken.

As regards the causes of these fistulae, various and numerous circumstances must be answerable. In those cases in which the X-rays demonstrated remaining cells which were not dealt with at the operation, one would naturally refer the reason to this condition. On the other hand, that the whole explanation lay in the non-treatment of such cells could not be the case because, in a great number of these conditions, no such remaining untreated cells could be demonstrated. This view was further supported by the fact that since he—the Exhibitor—had been particularly careful to remove all the surrounding cells in accordance with his own recommendation for a radical mastoidectomy, he had found that such retro-auricular fistulae were more common than formerly; nor could general constitutional conditions be accepted as answerable since, in the patient aged 10, whom he had shown and who was operated on on both sides at the same time, healing had been uneventful and complete on the one side, whilst on the other a fistula persisted.

The nature of the after-treatment was certainly also a factor but, in his opinion, the importance of this factor was much over-estimated. He could scarcely suppose that a fistula could be produced by firm packing of the wound. On the other hand, he could understand that certain unsuitable forms of dressings might lead to such a condition.

Many causes contributed, in his opinion, to the disturbance of the process of healing. First of all it would appear to him that the size of the antrum was an important point. For instance, the larger the antrum the more danger there was of it remaining open, owing to the invasion of the retro-auricular wound by the epithelium of the middle ear, and, that these disturbances in the healing of the wound occurred more frequently in children, was due to the fact that in children the antrum is relatively large. He did not consider it was in our power to prevent the formation of such fistulae, except in those cases in which it was decided to close the retro-auricular wound at the time of operation and when no further disturbance of such closure occurred. If however, it became necessary to re-open such a primary closure of the wound, then once more the conditions for a retro-auricular fistula were produced. Fortunately, we possessed various successful methods for plastic operation, but he did not wish to raise a discussion on this point. In the commentary which followed, the speakers confined themselves to consideration of the secondary plastic operations which such conditions demanded, and no reference, unfortunately, was made to the cause of such fistulae, to which the Exhibitor particularly wished the discussion to be restricted.

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Vienna Laryngo-Rhinological Society

Combined Middle- and Inner- Ear Affection with absence of Caloric Response but retained reaction to Rotation. Wassermann, negative. ? Otosclerosis. ? Lues.—H. NEUMANN.

A man, aged 51, was shown who had consulted the Exhibitor for deafness. The father, uncle, and a cousin of the patient were markedly hard-of-hearing.

The patient himself had been hard-of-hearing for some ten years and during that time had become comparatively deaf in the left ear, and complained of severe tinnitus on both sides.

Weber referred to the right. Rinne, right, negative; left, negative.

Hearing.—Right, whisper, nil. Conversation at ·5 metre. Left, no appreciation whatever for either speech or tuning forks. The picture would therefore correspond with that not uncommonly found in a case of old otosclerosis involving the inner ear.

Caloric Tests.—No response on either side. *Rotation.*—A reaction was obtained on both sides.

Internal.—Neurological and ophthalmic examination negative. Wassermann reaction negative both for blood and cerebro-spinal fluid.

The case was shown as a type of progressive deafness in which the affection of the cochlea was at first sight consistent with the appearance of otosclerosis, but which, as the result of responses to the vestibular tests, and in spite of the negative examination of the blood the Exhibitor regarded as due to lues; though possibly this was not the only factor. He proposed to keep the case under observation, to give some provocative injections, and bring him before another meeting later.

VIENNA LARYNGO-RHINOLOGICAL SOCIETY

Meeting March 1st, 1932

Abstract of Proceedings

By A. R. TWEEDIE

CASES

Stokes-Adam Syndrome. The Rôle of the Superior Laryngeal Nerve.—A. REINIGER.

The case in question was characterised by the occurrence of severe pain in the left side of the throat with every act of swallowing, even if this were only swallowing saliva. Objective examination revealed a normal condition. Anæsthetisation of the larynx and the left sinus pyriformis enabled nourishment to be taken without

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