LETTERS TO THE EDITORS

To the Editors,

The Journal of Laryngology.

Sirs,—Is it wiser to open and to drain the mastoid antrum in the early days of middle-ear suppuration, after the membrane has been opened, or to be content with simple meatal treatment? I am assuming, of course, that such signs and symptoms as continued pyrexia, unrelieved pain, mastoid œdema, and the like, are absent, since in these circumstances no divergence of opinion would be likely to arise.

It is not difficult to see that at the present moment otologists are divided into two schools: the older and more conservative operators who do not open the antrum unless there is some urgent call for the operation, and the younger and more radical who sympathise with the teaching of C. J. Heath on this point.

It is a well-founded reproach of surgery, as of medicine, that its votaries are the victims of fashion, and that not to be up-to-date or modern, whether that quality be good or bad, is to write oneself down as a back number.

This reproach we ought to do our best not to deserve, and that is the reason why I am now raising the subject for discussion, and, if possible, for settlement.

With regard to my own practice, if that is of any value to anyone but the writer (and his patients *bien entendu!*), I confess that as the years go on and my acquaintance grows, on the one hand with the grievous accidents attendant upon the "acute ear," and, on the other hand, with the very moderate success of the radical mastoid, my feeling is becoming more and more akin to that of the younger and bolder school, until I find that I am advocating and practising antrum drainage unless paracentesis and meatal antiseptics quite promptly lead to a drying-up of the discharge.

This attitude, as we all know, is what C. J. Heath has been advocating for many years, with a force and eloquence which I fear I must term intemperate, and which, I am sure, has retarded rather than advanced the cause he has at heart. In this view, however, I have come to agree with Heath, but I disagree totally with him in regard to the operation to be adopted.

After all, what are the objections to the simple opening and drainage of the mastoid antrum in the first days or weeks of suppuration of the middle ear? In skilled hands, the operation is a simple one, and its risks are certainly no greater than is the removal of the vermiform appendix *à froid*. On the score of operation-mortality, therefore, there need be no hesitation in operating early.

The real criticism, however, which early interference must face is this: Is the simple operation likely to cure a suppurating middle ear *more quickly* than meatal treatment? The kernel of the question lies in the words I have italicised. Time is the essence of the contract, as otologists surely would elect to adopt whichever method reduced the duration of the disease, even if it were only by one day.

Having propounded this question, I do not propose to answer it, as I should like to hear the experiences and opinions of my colleagues on the matter.

Another question is certain to be asked. It may be expressed in this way: Will early mastoid antrum drainage cure the middle-ear disease? The answer is that in a majority of cases it will, in a minority it will not.

The same question may be raised and the same answer can be given in discussing simple meatal treatment.

The crux lies here: Is the minority of uncured cases likely to be greater in number with drainage of the antrum, or with simple meatal treatment? Upon the reply to that question our practice will largely depend.

But there remains yet another aspect of the subject, which also we may set forth in the suggestive Socratic method I am adopting.

In addition to weighing the respective merits of the two methods of treatment as regards their effect upon the cure of the aural suppuration, we have still to consider this point: are complications more likely to occur if the antrum is drained at an early date or if the treatment is limited to the meatus? Or, I may alter the question to this form: when a complication occurs in the course of an acute suppuration of the middle ear under our care from the start, does not the otologist in charge of it sometimes feel that if he had drained the antrum earlier the complication in all probability would not have arisen?

The answers to these questions I leave to your readers. — I am, etc.,

DAN M'KENZIE.

TO THE EDITORS,

The Journal of Laryngology.

SIRS,—I am anxious to get an authoritative opinion upon "The Blood-Clot Method of Closing the Mastoid after the Simple Operation."

I am in the habit of opening the mastoid antrum if the discharge, *being free*, remains copious and persistent for three weeks, after careful local treatment has been carried out.

My object in so doing is to protect the delicate structures of the middle ear and secure complete repair of the membrane. Some

surgeons put the time limit down to ten days, and I am inclined to agree, provided careful local treatment has been used beforehand.

My cases sometimes take three to six months to heal, but the membrane, as a rule, becomes whole in a short time. Politzerisation during the later stages prevents contractions in the middle ear, and the resultant hearing is good.

To allow the wound to heal slowly from the aditus to the surface brings about almost complete obliteration of the antrum, and thereby lessens the risk of subsequent ear infection. Only a few cases show after-deformity, *i.e.*, a hollow behind the pinna. In these cases the disease has been more than a suppurative mastoiditis; there has been bone necrosis, peri-sinus abscess, or extra-dural abscess in almost all instances. The early closure seems to me to defeat the purpose we have in view. The proposal to insert a cigarette drain from the aditus to the skin, to allow the cavity to fill with blood, and to suture the wound, appears to me to be open to very grave objections. If a drain be needed, the infected material must, after twenty-four hours, when the bactericidal power of the blood has disappeared, affect the clot and disintegrate it. Where success has been achieved, it seems to me to be due to luck or to the fact that the operation was not necessary.—Yours, etc.,

J. A. MacGibbon, M.D., F.R.C.S. Edin.

Christchurch, N.Z.

GENERAL NOTES

Royal Society of Medicine,

1 *Wimpole Street, London, W.* 1.

Section of Laryngology—President, Sir William Milligan, M.D. *Hon. Secretaries*, Walter G. Howarth, F.R.C.S., and T. B. Layton, D.S.O., M.S. The next Meeting of the Section will be held on Friday, 3rd March, at 4.45 o'clock. Members intending to show patients or specimens should intimate the same to the Senior Hon. Secretary, Walter G. Howarth, 21 Devonshire Place, London, W. 1.

A discussion will be held on "The Treatment of Malignant Growths of the Nasal Accessory Sinuses." Mr E. Musgrave Woodman and Dr Reginald Morton will open the discussion.

Section of Otology—President, A. Logan Turner, M.D. *Hon. Secretaries*, Norman Patterson, F.R.C.S., and F. J. Cleminson, M.Ch. The next Meeting of the Section will be held on Friday, 17th March, at 5 o'clock. Members proposing to show patients or specimens, etc., should send notice along with a short written description of the same to the Senior Hon. Secretary, Norman Patterson, F.R.C.S., 16 Devonshire Place, London, W. 1, at least twelve days before the Meeting.

The Meeting of the Section in April will be held at Leicester on Saturday, the 29th of that month.