DISEASES OF THE MIDDLE EAR.

ROBERT M. LAPSLEY, M.D.

Professor of Ophthalmology and Otology, Keokuk Medical College, Keokuk, Iowa.
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The subject I have taken might amuse some of the members of our profession who have given years of study to the many pathological conditions embraced in this somewhat intricate subject, but I am taking advantage of the above title to make a few remarks on what I have observed here in Europe. I had the pleasure for some time of attending the various otological and rhinological clinics of London, and it seems to me the value of the clinics of our world's metropolis is somewhat underestimated. Clinical material is certainly abundant, and in many hospitals too much so for the size of hospital and staff. There are a number of good ear clinics in London, and considerable pains is taken in their management.

I was impressed more in London than any place else I have been with the great importance of adenoid vegetations in the naso-pharynx as a cause of middle-ear disease.

For some years this has been recognized as one of the chief causes of middle-ear disease in children, but an attendance at the Central London Throat Hospital made me believe that most children with middle-ear disease, in London, have adenoids. The method of dealing with these cases in large numbers has reached quite a degree of perfection there. On Friday afternoons, often dozens of cases are operated on, and all under an anæsthetic. I have followed a method widely used in America of placing the patient on a table with head over the end so the blood does not run down the throat, and, of course, the patient under influence of an anæsthetic, generally chloroform. Here the patient is seated in front of operator, given nitrous oxide gas, operated on by curette, forceps and finger nails, and in an extremely short time all is finished and the patient taken out. The method seems a good one in large numbers of cases, but in private practice is hardly necessary. The influence of these operations is naturally quite beneficial in most of the cases of the middle-ear disease, and it is quite likely it will materially affect the amount of ear disease in the generation now growing to manhood.

Dr. Dundas Grant makes considerable use of the injections of paroleine in chronic middle-ear catarrhs; and, by the way, he is

working in this large clinic with an enthusiasm and energy that is not only beneficial to his patients, but is rapidly making him one of the most popular of otologists.

The Golden Square Throat Hospital has also a large clinic—and the Royal Ear Hospital, while not so large, has a clinic in which much good work is done. For some weeks recently I have been attending the ear clinics of the eminent otologists of Vienna.

The name of Professor Politzer is known, probably, not only to all the medical profession, but even to most students of medicine. He is still working earnestly in the large clinic he controls at the Allgemeines Krankenhaus, and is doing much toward elucidating the many unsolved problems in otology.

One feels while listening to his lectures and watching his work that he is getting the most advanced thought.

This seems a great center of otology. Professor Politzer has many cases of suppuration of the middle ear, both acute and chronic, and it is interesting to note that he does not diagnose his ear cases until the ear is clean, and in many of the cases not until Siegel's otoscope has been used to demonstrate a cicatrix or a perforation. This seems very simple, but I have noticed the carelessness of so many otologists in these small but important matters. He is careful in chronic suppuration to cleanse the ear thoroughly, and to remove any cholesteatoma, if possible. In cases where a mastoid operation is found necessary, he usually does what he calls the radical operation; that is chiseling into the antrum and then removing the posterior wall of the canal. The Stacke operation, where only the outer wall of the attic is removed, and the antrum opened from the canal is seldom done. I mention this distinction because different people have described these operations to me differently.

Professor Politzer makes quite a point in exudative catarrh of performing paracentesis and removing the fluid by means of air douche, Siegel's otoscope, etc.

In chronic middle-ear catarrh he also uses injections of oil to some extent, and also simple inflations, massage and sometimes bougies.

I believe we are indebted to Dr. T. F. Rumbold, of St. Louis, for valuable work in the introduction of intra-tympanic injections of oil in treatment of ear disease, and I am glad to see it used so extensively and recognized as having merit.

Professor Urbantschitsch also conducts an interesting and instructive clinic. He also does the radical mastoid operation in many cases.

In his clinic bougies are used in the treatment of the middle ear and Eustachian tube quite extensively. He also uses electricity for chronic middle-ear catarrh.

I will review the few points I have attempted to give: First, in children with ear disease, adenoids should always be sought for, and, if found, removed; second, in the treatment of exudative catarrh the fluid should be removed from the middle ear; third, in the treatment of chronic catarrh, even in sclerosis, we should attempt the various methods of treatment (unless they seem to do harm) which consists in treatment of the cause, inflations, injections of gases or fluids, use of bougies, massage, electricity and possibly other methods; fourth, in treatment of suppuration as near antisepsis as possible should be carried out, and in proper cases operations must be resorted to. It must be remembered though that radical operations of the mastoid are accompanied by some danger, and should only be done where there is some positive indication. At best the after-treatment is prolonged, and while many operators say the operation is now rather simple, I have seen quite a number of cases of facial paralysis following operations by our most eminent men, and that should be sufficient, if there were no other reasons, to make one pause before doing such an operation, and see if it is really necessary.

Traumatic Rupture of the Tympanic Membrane—WM. BRAISLIN —*Am. Med. Surg. Bulletin*, Vol. xii, No. 12.

Seven cases are reported. The author's conclusions are:

1. Drum may be ruptured without direct impact of foreign body upon the membrane; *i. e.*, by the expansive force of air condensed within the canal.
2. Pre-existing middle-ear disease predisposes.
3. Some can be recognized by the present condition of opposite ear.
4. Prognosis of uncomplicated perforation was good.
5. With severe tinnitus prognosis should be guarded, as same may result from labyrinthine concussion.
6. Treatment till perforation is healed.
7. Subsequent treatment to middle ear is beneficial.

LEDERMAN.