

## ON AGORAPHOBIA IN RELATION TO EAR-DISEASE.\*

BY PROF. A. GUYE, AMSTERDAM.

Agoraphobia is a neurosis consisting in a fear or anguish to cross any larger or smaller open space. It is well known to the neurologists and psychologists since the description given of it by C. Westphal in 1872.†

Not long before him P. Benedikt‡ had described a few cases of the same kind under the name of "Platzschwindel." According to Benedikt, they stood in relation to a form of vertigo, caused by insufficiency of some eye muscles, especially the recti interni. Westphal and other authors who described cases of agoraphobia afterwards did not find this cause existing in their patients.

Legrand du Saulle§ then described a number of cases, and considered them as a form of neurasthenia, sometimes produced, according to him, by abuse of coffee.

E. Cordes,|| in the same year as Westphal, published twenty-nine cases, and in a later paper, in 1880, fifty-four new cases. He also considers agoraphobia as a symptom of "reizbare Schwäche," or a neurasthenic anguish, which is caused by exhaustion, by intellectual overwork, by sexual excesses, chronic gastric disturbance, or, in some cases, by the successful cure of obesity.

The neurologists and psychologists seem till the last time not to have noticed the relation of agoraphobia to ear-disease. The first who have done so, to my knowledge, are Lannois and Tournier in Lyon,¶ who published, a few months ago, ten cases of agoraphobia, in which various forms of ear-disease seemed to be the cause of the neurosis. They admit, of course, that there must be a neurasthenic disposition, but, according to them, this disposition existing, the cause of the special form of anguish, which we call agoraphobia, very often is some disease of the ear which causes subjective sound-sensations and vertigo.

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† *Archiv fuer Psychiatrie*, III, 138, 1872.

‡ *Allg. Wiener Med. Zeitung*, 1870, No. 40.

§ *Etude clinique sur la peur des espaces, névrose émotive*, Paris.

|| *Arch. fuer Psychiatrie*, III, p. 521, 1872, and IX, p. 48, 1880.

¶ *Lésions auriculaires cause d'agoraphobie. Annales des Maladies de L'oreille*, Paris, October, 1898.

In some of their cases there was purulent catarrh of the tympanum with perforation of the membrane, in others sclerosis, in one typical Menière's disease. In three cases they saw the agoraphobia disappear after the successful treatment of the ear-disease, and they think that would be more generally the case if the ear-disease itself were not in many cases so intractable.

I have a case in observation since 1880, whose history is, in short, as follows:

Miss X (M. 55), age thirty-three, who was and is still at the head of a large school, came under treatment in December, 1880.

She complained of slight deafness in her right ear since half a year; since two months she had ringing in that ear and now and then some giddiness at rising in the morning. But since two years she complained of agoraphobia, and was not able to go out alone. There was marked swelling and narrowness of the Eustachian tube on that side, chronic nasal catarrh, mouth-breathing, etc. Under treatment the condition of the ear was much improved, and only the agoraphobia remained. Since then there came frequent relapses, sometimes with very marked symptoms of Menière's disease, falling down, vomiting, etc. Under local treatment, and also under the influence of salicylate of soda (0.50—1 gramme twice daily), these symptoms generally subsided in a few weeks, but even when she had been for a year or longer without any vertigo or giddiness, the agoraphobia remained unaltered, and she is never able to go out alone. She does not fear an attack of vertigo, but she has the unexplained anguish to cross a place or street.

A remarkable feature in her case, which has also been noticed by some other authors in some cases, is that when in the country in her holidays she has sometimes been free of agoraphobia and been able to walk about alone for a few days, which she never is when in town. It may be that the frequent movements of the head in looking to the right and left, to which one is obliged in the busy streets of the town, produce slight rotatory sensations which unconsciously may influence the feeling of anxiety.

One other observation which she has made seems worth recording, that is, that after taking a few glasses of wine, being at a watering place with friends, she for the moment felt that she was nearly free of her complaint. Very rightly she did not wish to make use of this symptomatic means. Cordes (l. c.) also mentions the temporary benefit produced by wine in some cases. I have also observed the same in some cases of chronic Menière's disease, but would not, of course, advise it, as the danger of inducing alcoholism would be very great.

I have seen another case of a gentleman where very marked agoraphobia had existed for at least a year before he came under treatment for an acute middle-ear disease. This was successfully treated, but the agoraphobia remained. I can give no further particulars of this case, as the patient died a few years later without my having seen him in his last illness.

My observations in regard to this subject are limited to these two. I do not think that they throw much light on the subject, but nevertheless I thought it worth while to draw your attention to it, in the hope also that psychologists, when they see cases of agoraphobia, which I am sure they do now and then, will pay attention to the state of the ears, and by publishing their observations will promote the co-operation of men who cultivate different parts of the medical science.

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**The Semiologic Value of Hemorrhage from the Ears**—TILIAUX—  
*Journ. des Méd. et de Chir.*, September 10, 1898.

After a traumatism, such as a fall from a high place, or a fall upon the chin, otorrhagia may be due to the following conditions:

1. When there already exists an inflammatory lesion of the tympanic cavity.
2. When there is a fracture of the external auditory canal.
3. When there is rupture of the tympanum.
4. When the base of the brain is fractured.

In addition to these, a history of the case and the general condition form a valuable aid in making the diagnosis.

SCHEPPEGRELL.

**A New Method of Mobilizing of the Stapes**—FARACI—*Archiv. Ital. di Otol., etc.*, VII. 4.

After describing the advantages of this procedure, the author advocates the mobilization of the stapes by a method which enables the operator to leave undisturbed the ossicular chain. A myringectomy is first made and then resection of the external wall of the *aditus ad antrum*. After the operation the tympanic flaps are replaced. The author prefers an instrument similar to those used by oculists for extraction of cataract, with such modifications as are required by the character of the case. He reports two cases with satisfactory results.

SCHEPPEGRELL.

## MASTOID OPERATIONS.\*

BY W. F. COLE, M.D., WACO, TEXAS.

It was before this Association, one year since, that I made my report of mastoid operations by means of the dental engine, using cocaine as an anesthetic. At the last meeting I presented before you a patient on both of whose mastoids I had operated. I had intended to present before you again to-day the same patient, who has made complete recovery, but unforeseen circumstances prevent.



Figure 1.

I have here this patient, on whose left mastoid I did this operation about the 20th of December, 1898. This man had been suffering with mastoiditis on the left side for about a year, following an attack of la grippe. Although he has been a man of powerful physique, he had become unable to follow his occupation of engineer. He suffered with tenderness over left mastoid and whole side of head.

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\*Clinic and Report of Cases by Dr. W. F. Cole, before the Central Texas Medical Association, January 12, 1899.

The sterno-cleido-mastoid muscle was very tender from mastoid to sternum, and he constantly inclined his head to that side. No sup-puration had ever occurred in the ear, and the drum membrane showed little evidence of inflammation.

I diagnosed the case as necrotic condition of middle and lower mastoid cells, with possibly some involvement of antrum.

This is the fifth case in which I have operated in this way, and I feel confident that my method is destined to supersede all others. I have pleasure, therefore, in presenting this case before you, and will detail my method in full. I explained this operation in Atlanta in March last. I have since reported it to many physicians in London, New York, Chicago and other places, and so far as I can learn I am the first to do this operation in this way, that is by using the dental drill with cocaine as an anesthetic.

As I have already reported in papers, which have been published, my first operation was a matter of necessity, because the patient could not take a general anesthetic. A description of the operation upon this patient will, in a general way, do for all operations. This man sat upright in a chair. I injected a sterilized cocaine solution beneath the skin where I intended to do the operation. Attaching this cutting trephine (see cut) to the engine, I cut out a plug of skin

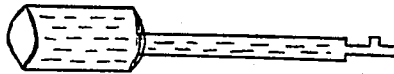


Figure 2. Cutting Trephine.

down to the bone instantly, this being the only painful part of the operation. Removing the plug of skin, I applied cotton, saturated with a solution of chromic acid with considerable pressure. This quickly checked the hemorrhage. I cleaned the bone of muscular tissue with the electric cautery. With a boring drill I perforated the outer table, making a small opening, after which I used a large dental burr. I am pleased to exhibit to you the instruments which I used. The whole operation with the engine took less than ten minutes, and the patient here will assure you that the operation was not more painful than ordinary dental work.

I found a condition in the mastoid cells resembling tubercle, which I curetted out carefully.

The probe passed readily into the antrum. On irrigation, the fluid passed readily down through the nose.

I used a bichloride solution for a few days, when I allowed the wound to close internally, keeping the external wound open as you see.

The patient has grown better from the first, and now, after twenty days, he is practically well.

The other cases which I have had all had suppuration of the middle ear, but as you see in this case I did not even break the drum, and the hearing was never seriously affected. I am delighted with this method of operating, not only because of the results, but because of its simplicity and safety. I did my first operations with much trepidation, but now I do the operation with as little hesitation as I do when I open up the superior maxillary sinus.

I regard the operation as not only more safe, but it has the advantages of doing no unnecessary damage to any part of the ear, and no unsightly scar is left. I feel sure that this operation will appeal to all rational aurists.

In order that you may contrast this method with the usual one, allow me to describe the operations as I saw them done in London during last summer. One hot evening in August I visited a celebrated ear and nose hospital, where I saw two operations done by what is known as the radical operation. The poor patient was put under complete anesthesia. A tremendous incision was made through the skin. The auricle was pulled forward, and skin separated from the bony meatus. The hemorrhage was profuse, keeping one assistant busy with sponges, while two held the wound open with retractors, and the principal proceeded with mallet and chisel to open the mastoid. When the cells were laid bare the whole of the posterior wall of the bony meatus was removed. The incision in the bone was then smoothed with a hand-burr with such force that I feared that the instrument would pierce the brain. Then the skin of the meatus and base of auricle was split posteriorly, the operator running his finger through the opening. The base of the auricle was pulled back, and stitched to the posterior part of the wound. I think I am correct when I say that five able-bodied men and a nurse were more or less actively engaged in this operation, besides one man to wipe the perspiration from the principal surgeon.

I have described this operation specially in order to emphasize the contrast. The description is in no sense a criticism upon the distinguished English surgeons, who as a class are not excelled in the world for ability and courtesy.

While the cure by means of the radical operation is said to be more assured, yet it has some serious drawbacks which should, in my

estimation, prevent its being done except as a last resort. A hideous deformity of the auricle necessarily results; the ossicles and membrana tympani are destroyed, removing all chances for the recovery of useful hearing.

I saw a number of patients attending the hospitals in London on whom this operation had been performed many months previously, and some of them complained bitterly that useful hearing had been destroyed, resulting in total deafness. I confidently predict that such operations will quickly be abandoned because they are irrational; and with it will also go the operation known as ossiculotomy, which has resulted in such an indiscriminate destruction of essential appendages.

With this paper is presented a photograph (figure 1) of the patient exhibited in the clinic. The picture was taken on the same day of the clinic.

A cut of the cutting trephine (figure 2) is also presented—natural size. This trephine may be obtained from Truax, Greene & Co. The kind of drill-handle should be stated.

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**Exophthalmic Goitre**—A. SHAFFER—*Occidental Med. Times*, Vol. xii, No. 12, December, 1898.

The writer's own original ideas are described in this article. He holds that though exophthalmic goitre has primarily all the marks of a pure neurosis, and though the subsequent cardiac and abdominal disturbance soon become prominent, the thyroid is the dominant factor in this disease. He believes it probable that under a peculiar stimulus, the thyroid gland itself throws into the circulation enormous and toxic quantities of its normal secretion. That this secretion has a powerful effect on nutrition, and in large doses is capable of producing the most marked disturbance, has lately been repeatedly demonstrated. He thinks the opinion justified that the thyroid in ophthalmic goitre exhibits signs of increased functional activity as the result of pathologic examinations.

Myxedema is the antipode of goitre, as in the former we have a decreased or abolished secretion due to atrophy or ablation, there being enormous increase of interstitial tissue so as to completely or quite obliterate the secreting function of the gland. The mental and other symptoms in one disease are sharply in contrast with those of the other.

Should his theory prove correct, he believes the removal of the gland justifiable.

EATON.