Chronic Middle Ear Suppuration

SIR,—I think that a description of treatment of chronic middle ear suppuration by a very simple and efficient method is worth while. These cases can be divided into two classes: (1) Cholesteatoma. (2) Other chronic cases of otitis media—I am not considering such conditions as malignant disease, tuberculosis, etc. The nature of the discharge is of some importance—that is, whether it is mucoid or purulent—but a condition of great importance is the odour of the discharge. There may be no odour; these cases are amenable to simple treatment. On the other hand the discharge may have an offensive odour, which may be either the nauseating stink of a true cholesteatoma or simply a bad smell from putrefaction. Chronic middle ear suppuration is of course primarily due to infection from the upper respiratory tract, including the nasal accessory sinuses, and proper care of these conditions is essential in treatment. However, there are other factors of importance such as the general health, the patient's constitution, family and economic considerations—these conditions all require attention.

Doctor and patient should both fully understand that the essence of treatment is to keep the ear clean and dry. It must also be realized that in the presence of a perforation of the tympanic membrane, unless the Eustachian tube is completely obstructed, reinfection of the middle ear is constantly recurring and is inevitable when sepsis from the upper respiratory areas is forced into the middle ear by blowing the nose, etc. If the perforation is completely sealed then this "through channel" of infection is eliminated. The size of the perforation has little bearing on the actual treatment; if the perforation is so small that the tympanic cavity cannot be easily treated it means that the suppuration is very mild and will recover itself if permitted; if the perforation is larger, access to the tympanic cavity is facilitated.

The first step is to eliminate the odour, and this can be done by thorough mechanical cleansing; and in doing this the shape of the auditory canal must be realized. Patients can be instructed to do this by the method taught by Prof. Neumann, of Vienna, rolling a small fine-pointed cone of wool about 1 in. (2.5 cm.) in length and gently tucking this into the canal, repeating until every corner is cleansed properly, and then instilling one or two drops of alcohol. This is done as often as is necessary to keep the ear clean and dry; it is a safe method, is ideal for children, and the patient's friends can be taught. In a week or ten days, if properly carried out, the odour, except in the presence of cholesteatoma, will have gone, and the next line of treatment is used. This consists of what I call the "pipette and powder" treatment, and again the patient's relations can learn to carry it out.

The patient lies on the side with the ear to be treated directed upwards. The ear is carefully mopped out, and then irrigated with aqueous solution of acriflavine (1 in 1,500) by means of a rubber-capped pipette. By squeezing and releasing the rubber cap the tympanic cavity is gently washed out, unless the perforation is so small that it is unnecessary. A few pipettefuls of acriflavine will cleanse the cavity. It is now carefully but thoroughly dried once more, and the ear canal is filled with powder which is actually tamped well into the canal, and then a small pledget of gauze inserted to prevent the powder from falling out. The nature of the powder is of minor importance; it is not the chemical action of the powder that is important but the mechanical "corking" of the perforation to prevent infection being forced into the middle ear. I have used plain boracic powder, boracic and iodine powder, penicillin and sulphanilamide powder. The results are the same. Plain boracic powder is "lumpy" and not so easy to manipulate. Penicillin and sulphanilamide powder is a fine dry powder easy to use, but may be followed by an allergic dermatitis. Boracic and iodine powder (0.1% iodine) is a good powder, but occasionally a patient is sensitive to iodine.

If discharge persists the powder will quickly be softened, and to the non-expert gives the appearance of profuse pus. In such a case it is necessary to repeat the treatment until the powder is found to remain dry. When the powder remains dry all that is necessary is to put in more powder as often as necessary to keep the ear filled. This "cork" or "plug" of powder is kept in the ear for three months or more, but it must on no account be allowed to be wetted—it must be kept clean and dry. After three months the powder may be allowed to disintegrate. It interferes very slightly with hearing after the first few days. It is surprising to find the number of even fairly large perforations that are found healed when this powder eventually disintegrates. I have not used this method with a genuine cholesteatoma, but then genuine cholesteatoma is becoming rarer, being merely a result of neglect or wrong-

ful treatment; the best treatment is prevention. The "pipette and powder" treatment is equally applicable to the later stages of acute otitis media, which is the precursor of chronic otitis media, and which is so often prolonged by reinfection by means of the "through channel," nose blowing, etc.

Once more I wish to stress the point that in the conservative treatment of chronic middle ear suppuration it is necessary to realize that the condition is much more than just a localized infection in an area which appears to be somewhat difficult of access. When properly administered the sulphonamides and penicillin are of considerable value, but their use does not prevent reinfection, and the principles enunciated—namely, the keeping of the ear clean and dry and the prevention of the "through channel" of reinfection—must be observed.—I am, etc.,

Brisbane, Queensland.

ERNEST CULPIN.

Limb Haemangiectasis and Cirroid Aneurysm

SIR,—In regard to examples of the association of developmental haemangiectatic hypertrophy of limbs associated with cirroid aneurysm I think there is still a tendency to regard the cirroid aneurysm as the cause of the limb enlargement instead of recognizing that both conditions are due to some developmental abnormality, probably during early intrauterine life, in the nervous regulation of the blood supply and nutrition of the affected part. Certainly the same type of limb enlargement occurs in the absence of any actual cirroid aneurysm. Typical cases are distinguished by increased length of long bones in the affected extremity; often there are vascular hamartomata in the affected extremity, sometimes in other parts of the body. The bony enlargement seems to be connected with increased arterial blood supply, possibly associated with increased size of the nutrient artery. Occasionally apparently similar cases are met with in which no enlargement of long bones can be made out. Can it be because in such cases the nutrient blood vessels of the bones are not involved? Sometimes parts of the body other than limbs have been similarly affected by what one may term "haemangiectatic hypertrophy." Some cases of hemihypertrophy appear to be the result of a similar developmental agency. Probably the rare cases of monstrous "true gigantism" of fingers, toes, hands, or feet are due to a somewhat different developmental agency.

My excuse for writing this letter is that I have taken continuous interest in the subject since my article on "Haemangiectatic Hypertrophy" in 1918 (*Brit. J. Child. Dis.*, 15, 13). Since then my name has frequently been attached to the syndrome in Britain and other countries as well as the name of Klippel, who stressed the "osteo-hypertrophic" changes associated with the dilatations of blood vessels (cf. also F. P. Weber, "Angioma Formation in connexion with Hypertrophy of Limbs and Hemihypertrophy," *Brit. J. Derm. Syph.*, 1907, 19, 231).—I am, etc.,

London, W.1.

F. PARKES WEBER.

Erythroblastosis Foetalis and Breast-feeding

SIR,—The case report by Dr. Rosemary Davies (Jan. 25, p. 138) of a breast-fed child with erythroblastosis foetalis in which recovery followed the cessation of breast-feeding calls for some comment. The recovery may well have been due to the transfusion of 170 ml. of blood—about one-half of the child's total blood-volume—two days after the institution of artificial feeding. It is also well known that infants who for some reason have lost much blood frequently require more than one transfusion before recovery occurs.

It has been repeatedly shown^{1,2} that small quantities of protein, capable of producing immunity responses and thus presumably undigested, are absorbed in infants, and hence the theoretical possibility that agglutinins could be absorbed from breast milk. But the amount of undigested protein absorbed in this way is minute compared with the total quantity ingested and digested, and it would be surprising if, of the agglutinins present in breast milk, sufficient could be absorbed to be of any clinical importance. The presence of Rh antibodies in breast milk does not necessitate their absorption, and as far as I am aware no direct evidence of the intestinal absorption of Rh antibodies has been recorded. It would be a very great pity at our present

state of knowledge if infants with haemolytic disease of the newborn, or, what would soon follow, if infants with anaemia or jaundice suspected of being due to Rh antibodies, were subjected to the known increased hazards of artificial feeding when there is as yet no evidence that breast milk is in any way harmful in these cases.—I am, etc.,

Sheffield, Yorks.

JOHN L. EMERY.

REFERENCES

- 1 Du Bois, R. O., Andresen, A. F., and Schloss, O. M. (1925). *Proc. Soc. exp. Biol.*, N.Y., 23, 176.
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Women Doctors and Service Specialist Appointments

SIR,—The Medical Women's Federation has been informed of the extreme difficulty which is being experienced in finding replacements from civilian life for the specialists (men and women) in the Services whose release is behind all other medical personnel—in the Army, for instance, it is 12 groups behind. There is at present no conscription of women. As many women doctors know, in June, 1945, the Ministry of Labour, by a Cabinet decision, abandoned the call-up of women and the doctors were included in the general ruling. The Medical Women's Federation wrote a letter at the time to the Ministry of Labour, which was afterwards reported in the medical Press, pointing out that this exemption was contrary to the wish of medical women; it deplored the position and said that in professional matters women doctors wished to be treated as doctors and not to have special privileges as women. Similar representations were made by the Services themselves and by the Central Medical War Committee. The Ministry of Labour, however, was not willing to rescind the order as applying to women doctors, but pointed out that they were at liberty to volunteer.

It must be admitted that recently the Service intake of volunteer women doctors has been very small; this has had the unfortunate consequence of delaying the release of serving specialists, both men and women, and of necessitating the call-up of an unfair proportion of men doctors, many approaching 40, on whom it may inflict serious hardship. Young women of the graded or full specialist class must realize furthermore that their immunity from conscription is certainly not entirely to their advantage. B1 posts and higher hospital appointments are being reserved to a great extent for returning Service doctors or for those who are "recruitable," in order that, in the latter case, there shall be some specialists trained in due course to replace those who are now going into the Services.

The Medical Women's Federation wishes to draw the attention of all young women specialists to this urgent need, recognizing, however, that this is only a short-term measure. Long-term policy involves the consideration of the conscription of women doctors equally with men, but this is bound up with the rectification of certain anomalies in the status of medical women serving with the Army and R.A.F. In spite of this, however, the Federation urges eligible women specialists to offer their services now, chiefly for the sake of those who are being retained unwillingly or called up, and perhaps also for their own sakes as, on leaving the Services, they will be in a strong position in applying for further appointments.—I am, etc.,

MARY F. LUCAS KEENE,

Bromley, Kent.

President, Medical Women's Federation.

Food for Invalids

SIR,—I have been reading the interesting debate in Parliament on Jan. 22 (*Journal*, Feb. 1, p. 204) on this subject. The accounts given by the *British Medical Journal* and by the *Lancet* are substantially the same, with one very important exception. The following paragraph which appears in the *Lancet* does not appear in the *British Medical Journal*:

"Mr. S. Hastings asked the Minister if he would give figures to compare the amount of priority milk ordered by doctors in residential areas such as Bath, Bournemouth, Hove, or Hampstead with that in industrial areas like Tyneside or South Wales. Mr. Strachey: In December, 1946, the number of domestic consumers obtaining priority milk on medical grounds per thousand of population was Bath and Bathaven, 31; Bournemouth and Christchurch, 38; Hove and Brighton, 33; Hampstead, 47; Tyneside, 15; S. Wales, 15."

I am not for the moment concerned as to what is the explanation for the interesting fact that there are more than three

times as many persons receiving priority rations in Hampstead than in Tyneside, but it would be interesting to know why the *British Medical Journal* omitted to report this question and Mr. Strachey's answer to it.—I am, etc.,

University of Manchester.

ROBERT PLATT.

** Because our Parliamentary correspondent did not report the passage quoted above, presumably in order to allow space for a fuller report of other matters excluded from the pages of the *Lancet*.—ED., *B.M.J.*

Non-agenized Bread

SIR,—I care not for the finer points in the differential diagnosis of hysteria in dogs, neither would I wish to dissuade white-bread eaters from consuming agenized flour—bleached with NCl_3 —should they so wish to do. I have, however, a foolish personal prejudice against eating bread made from flour which produces fits, whether hysterical or not, in dogs and which may cause their death after a few weeks.

Is it possible now to obtain bread made from plain whole meal, not improved in any way and with no extraneous substance added or none of the whole meal removed? Is there any easy test one could apply to make sure that the flour has not been improved—something like the "starch and iodide" test for free chlorine? Finally, Sir, I should be grateful for information as to where, pending any action which may be taken by the various ministries concerned, I can obtain guaranteed non-agenized bread in the London area.—I am, etc.,

Harrow. Middx.

W. MUNRO LESLIE.

Endogenous Depression in General Practice

SIR,—I first hasten to inform Dr. A. L. Rowson (Feb. 15, p. 271) that my question was asked in good faith and was not intended to be either rhetorical or rude. I did not realize that he had had institutional experience in psychiatry. I imagine that all who work in mental hospitals would be glad to see both change and development. Many experienced psychiatrists have in fact practically pleaded for certain improvements, and I see no objection to a Royal Commission.

But as I do not think that things are as bad as Dr. Rowson would have us believe I would take up a few of his points and emphasize some safeguards. The first is the increasing use of admitting patients without certificates, either as voluntary boarders or temporary patients. No one is allowed to detain a voluntary boarder for more than three days after he has given in his notice to quit; so if either the patient or his relatives think he is unhappy, or not making progress, he can go.

Then as regards E.C.T., this is never given or continued without the patient's consent, and if no progress is being made the treatment is stopped. I simply do not understand the statement—no reference being given—that patients fear electrical convulsions, though this was not uncommon when chemical convulsants were in use. Is Dr. Rowson perchance thinking of intravenous cardiazol or its analogues? In any case the patient can always refuse a second treatment. Nor, I submit, is E.C.T. customarily given without previous psychotherapy and diagnosis. The development of the clinic to which the doctor either brings or sends his patient has great possibilities and, let us hope, will be used more frequently still.—I am, etc.,

Cambridge.

A. KNYVETT GORDON.

** This correspondence is now closed.—ED., *B.M.J.*

Treatment of Patients

SIR,—Dr. Kenneth Sheldon (Feb. 1, p. 195) drags up the old, old accusation that there is one law for the private patient and one for the panel. He talks about "the proud boast of the principal has been how many patients he could dispose of in the hour . . ." Why not? Surely patients have no wish to sit for hours in a doctor's waiting-room while the latter spends twenty minutes on each case of impetigo or scabies?

One can very easily dispose of, say, fifteen cases of "repeats" of medicine, certificates, injections, and short "spot diagnoses" in from half to three-quarters of an hour—and these are what the bulk of our surgeries consist of—and inform the others that their case may take some time to go into and that it would be preferable to do it in their own homes at their own bedside.