

Letters to the Editor

How to make the invisible anterior tympanomeatal angle visible

Dear Sir,

Peltola and Saarento (1992) in their Short Communication propose a 'new method' to visualize foreign bodies hidden in the anterior tympanomeatal angle by administering water in the ear canal of the patient (who should lie on his back with his head tilted). While I agree that this trick does work I came up with a different explanation of how the water might assist in visualizing this commonly invisible area (Wind, 1984). I assumed – and still assume – that the water surface adopts a convex position rather than a concave one as Peltola and Saarento think. Also I mentioned that the oblique position of the surface relative to the optical axis of the microscope adds to the desired effect by obtaining refraction (cf. the oblique-stick-in-the-water effect). While it might be worthwhile to conduct some experiments to assess the (positive or negative) relative contributions of both mechanisms to the effect concerned, I do not believe that simply washing out the ear wax, as suggested by the authors, suffices to remove all the wax from the ear canal skin and so obtain the water surface adopting a concave shape.

Yours faithfully,
Professor Jan Wind,
Gooi-Noord Hospital,
P.O. Box 900,
1250 CA Laren,
Netherlands.

References

- Peltola, T. M., Saarento, R. (1992) Water used to visualize and remove hidden foreign bodies from the external ear canal. *The Journal of Laryngology and Otology* 106: 157–158.
Wind, J. (1984) Making the invisible anterior tympanomeatal angle visible. *Laryngoscopy* 94: 413.

Branchial cyst and cervical cystic metastases

Dear Sir,

In discussing the diagnostic confusion and difficulty between branchial cyst and cervical cystic metastases, Bath *et al.*, 1992, advocated endoscopy, ipsilateral tonsillectomy and blind biopsies of Waldeyer's ring, combined with excision of the cervical lesion in patients over 40 years old. They failed, however, to be clear whether that was applicable on every case of branchial cyst or cervical cystic metastases. If it was for the former condition, that may be considered indulgence in over, and unnecessary, investigation, and if it was for the second, we agree that it is appropriate to obtain blind biopsies, where the likely primary may exist even if this area is normal at endoscopy. In every case, however, the first step must be to

excise the cystic mass in the neck for histological examination with a comprehensive head and neck examination.

Cervical cystic metastases may indeed be misdiagnosed as a branchial cyst by the unwary because of its location, but it should not be forgotten that the only absolute proof of the nature of any cystic mass is its histological examination. The difficulty, however, would arise only if two conditions combine—first, an occult primary and second, a cystic degeneration in a metastatic node. This may suggest a tumour arising in a pre-existing branchial cyst (malignant branchioma). It is certain that the great majority of these tumours so-designated are metastases from a primary growth elsewhere (Willis, 1960). In such cases we feel that it is illogical to subject patients to ipsilateral tonsillectomy for the following—firstly, the source of occult primary can be anywhere in the different parts of Waldeyer's ring (Micheau *et al.*, 1990) and secondly tonsillectomy may not contribute too much to the whole outcome if these patients are treated as we advocate in a report to be published soon with a prophylactic radical course of radiotherapy to the whole region of Waldeyer's ring, in addition to removal of the cystic mass (El-Sharkawi and Williams, 1992).

Yours faithfully,
A. M. M. El-Sharkawi and G. T. Williams,
Singleton Hospital,
Sketty,
Swansea SA2 8QA.

References

- Bath, A. P., Murty, G. E., Bradley, P. J. (1992) Branchial cyst—to endoscopy or not. *The Journal of Laryngology and Otology* 106: 1006–1007.
El-Sharkawi, A., Williams, G. (1992) Malignant branchioma—a further insight. *European Journal of Surgical Oncology* (accepted).
Micheau, C., Kljanienco, J., Luboinski, B., Richard, J. (1990) So-called branchiogenic carcinoma is actually cystic metastases in the neck from a tonsillar primary. *Laryngoscopy* 100: 878–883.
Willis, R. A. (1960) *Pathology of tumours*. Butterworth Medical Publishers, London, pp 235–306.

Dear Sir,

El-Sharkawi *et al.* (1992) fail to appreciate that it is in those patients over 40 years of age that we advocate unilateral tonsillectomy. To understand the rationale behind restricting it to that age group requires understanding of the aetiology of the two conditions, and we refer them back to our discussion (Bath *et al.*, 1992) with particular reference to paragraphs 1 and 6.

They further fail to appreciate that unilateral tonsillectomy is a diagnostic rather than a therapeutic procedure. We believe that the identification of the primary site where

possible prior to radiotherapy is sound oncological practice and cannot support their policy of blind radiotherapy to the whole of Waldeyer's ring.

Yours faithfully,

A. P. Bath, G. E. Murty, P. J. Bradley,
ENT Department,
Norfolk and Norwich Hospital,
Brunswick Road,
Norwich NR1 3SR.

References

- El-Sharkawi, A., Williams, G. (1992) Malignant branchioma—a further insight. *European Journal of Surgical Oncology* (Accepted).
Bath, A. P., Murty, G. E., Bradley, P. J. (1992) Branchial cyst—to endoscope or not? *The Journal of Laryngology and Otology* **106**: 1006–1007.

Patient satisfaction in ear surgery

Sir,

In your Editorial 'The aims of middle ear surgery to improve hearing' (*Journal of Laryngology and Otology* **107**: 1–3) Professor Browning rightly draws our attention to the difference in the definition of surgical success following tympanoplasty and stapedectomy that may exist depending on whether one is the surgeon or the patient. The idea that patient satisfaction might be considered rather than the more easily measured air-bone gap is one which we have been curiously slow to adopt but is one of the more tangible results to emerge from the amorphous fog of audit. I should like to develop the theme a little further to embrace two other topical areas in which there may similarly be some variance between surgeon and patient in perception of success.

Hearing preservation is seen as the new great objective in acoustic schwannoma surgery and of course such an aspiration seems highly laudable. However when one considers that, in the case of a unilateral tumour, the hearing in the opposite ear is nearly always normal, the surgeon has to be able to retain a hearing level of 30 dB or better for the patient to be aware of this great surgical success. Furthermore whereas in middle ear surgery the deafness usually results from signal attenuation alone, in the case of an acoustic schwannoma, the problem is compounded by distortion factors such as poor speech discrimination and abnormal adaptation. It is a common experience for patients who lose their debased residual hearing actually to report an overall improvement in their general speech intelligibility after translabyrinthine surgery. Our experience indicated that only 10 per cent of patients had a pre-operative interaural pure tone difference of ≤ 30 dB, SD of ≥ 50 per cent and a tumour of ≤ 2 cm. Tightening the criteria, less than 1 per cent had a PT difference of ≤ 20 dB, SD of ≥ 50 per cent and a tumour of ≤ 1 cm (Hinton *et al.*, 1992). Unless therefore one hopes for an improvement in hearing after hearing preservation sur-

gery, and there is little to suggest that this often occurs, the numbers of patients who are candidates for this surgery is at present small although earlier diagnosis may increase the numbers a little. Sanna *et al.* (1992) summarize well the lack of precision that still exists in defining criteria for surgery, and for success, and highlights the 'surgical triumph which may not be appreciated by the patient'. In the case of NF2 of course the situation is different and any hearing which may be preserved and which may be subsequently assisted with a hearing aid may be of immense value.

With cochlear implantation the situation is subtly different. The best result from an implant is the patient who can follow conversation without or with minimal dependence upon lipreading and can converse on the telephone. These are the so called star patients and they may make as many as 50 per cent of a large series. Such results delight the surgeon and the implant team. It would however be very wrong to regard patients with a lesser level of performance as failures. Those patients who fail to achieve much open set discrimination and who use the device as a means of enhancing their communication skills by supplementing lipreading, nevertheless have their quality of life greatly enhanced. The level of patient satisfaction, regardless of objective measurement of performance, is very high; there are very few speech processors lying in drawers unused. It is important for surgeons to be aware of these facts. It would be relatively easy to produce a pure strain of star patients by for example excluding all patients who had been deaf for more than say 5–10 years. To do so however would deny a large number of potentially happy implantees the immense benefits of this revolutionary technology.

Professor Browning was right when he suggested that in ear surgery, measure by all means that which is measurable, but do not forget to ask the patient what he or she thinks about the results of our efforts.

Yours faithfully

Richard Ramsden,
Department of Oto-laryngology,
University of Manchester,
Manchester Royal Infirmary,
Oxford Road,
Manchester M13 9WL.

References

- Browning, G. G. (1993) The aims of middle ear surgery to improve hearing. Editorial. *Journal of Laryngology and Otology* **107**: 1–3.
Hinton, A. E., Ramsden, R. T., Lye, R. H., Dutton, J. E. M. (1992) Criteria for hearing preservation in acoustic schwannoma surgery: the concept of useful hearing. *Journal of Laryngology and Otology* **106**: 500–503.
Sanna, M., Gamoletti, R., Tos, M., Thomsen, J. (1992) Symposium on hearing preservation after acoustic neuroma surgery. *Acoustic Neuroma*. (Proceedings of the First International Conference on Acoustic Neuroma, Copenhagen, Denmark, August 25–29 1991). Kugler Publication, Amsterdam/New York, pp 985–987.