

ABSTRACTS

EAR

Interpretation of Hearing Tests. STACY R. GUILD, Baltimore. *Journal Amer. Med. Assoc.*, 1950, cxlii, 466.

A clear distinction should be made between hearing tests for research purposes and tests for clinical purposes. It is usually difficult to determine how much of a patient's deafness is due to conductive factors and how much is caused by disease of the neural mechanism. In such common conditions as impacted cerumen, fixation of the stapes, all forms of middle-ear disease and tumours, the tuning fork and audiometer test, typically show good hearing by bone conduction and impaired hearing by air conduction. The ratio of air conduction time is affected by all conductive lesions and the possible presence of a conductive lesion is not ruled out when the answer to the qualitative test is that the fork sounds louder by air conduction than by bone conduction. It is necessary to time the duration of hearing by each route. Clinical otologists might well discard the classic concept that a greater loss of hearing for high tones than for low tones always means a nerve deafness. Otologists, in spite of any advances in methods of testing hearing, must continue to rely chiefly on the clinical history and the physical examination in order to determine why a patient is hard of hearing and what can or should be done about it. The article is freely illustrated and has a bibliography.

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Evaluation of Dizziness. DAVID D. DEWEESE, Portland, Oregon. *Journal Amer. Med. Assoc.*, 1950, cxlii, 542.

Orientation of the body in space is controlled by a complicated system which includes the eyes, proprioceptive system, the labyrinth and the cerebellum. In taking the history it is important to determine whether the patient has experienced true whirling. If a sense of motion cannot be proved, the entire body becomes the field of investigation. If hearing loss or tinnitus accompany the dizziness location of the cause becomes easier although true vertigo can occur without hearing loss. Aggravation of the dizziness by a change of position causing nausea and vomiting is most frequently due to an end organ. The most important physical sign is spontaneous nystagmus. Vertical or diagonal nystagmus or nystagmus in different directions in the two eyes is indicative of central nervous system disease. Impacted wax, foreign bodies, trauma of the middle ear and suppurative otitis media are probable causes of dizziness. Tuning-fork tests and audiograms should always be done but there are few audiograms of specific diseases. Disturbances of equilibrium and diminution of cochlear function parallel each other but brain stem lesions may give rise to dizziness without hearing loss. Hypo-activity, hyper-irritability or complete loss of function are all that can be learned from caloric tests. Acute infectious diseases of the central nervous system such as meningitis,

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encephalitis and increased intracranial pressure and general conditions such as tabes, pellagra, pernicious anæmia and heart insufficiencies have to be considered. In skull fractures hæmorrhage may destroy the end organ entirely but slow compensation can be expected in three weeks' time. Acute toxic labyrinthitis may occur after food, alcohol and other drugs. Compensation neurosis and outright malingering are common and difficult to distinguish from true dizziness.

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ŒSOPHAGUS

Diagnosis of Lesions near the Cardia. JOHN H. FITZGIBBON, Portland, Oregon. *Journal Amer. Med. Assoc.*, 1950, cxlii, 453.

The more common lesions of or near the cardia include congenital stenosis, cardiospasm, diffuse spasm of the œsophagus, carcinoma, hiatus hernia, œsophagitis, peptic ulcer, diverticula, varicosities, cascade stomach, foreign bodies and eventration of the diaphragm. Patients with these lesions have one or more of the following symptoms: dysphagia, substernal distress, regurgitation, heartburn, hæmorrhage, weakness and loss of weight. Cough is caused by aspiration of regurgitated material and is usually worse at night. Roentgen examination of the œsophagus should be considered inadequate unless the upper part of the stomach and the lower end of the œsophagus have been studied both in the horizontal as well as in the upright position. Babies with extreme stenosis of the œsophagus have dysphagia with the first feeding. Cardiospasm, diverticula and œsophagitis are often associated and pain may be severe. The œsophagoscope is useful in all cases, more particularly in varicosities, new growths and foreign bodies.

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MISCELLANEOUS

Anticoagulant Therapy in Surgery. GEZA DE TAKATS, Chicago. *Journal Amer. Med. Assoc.*, 1950, cxlii, 527.

The writer bases his observations on the vascular surgical service at St. Luke's Hospital, Chicago. Thrombo-embolic disease following surgery has greatly decreased during the last decade. Rational anticoagulant therapy is based on certain fundamental principles: (1) a certain section of the population carries an increased tendency to clotting; (2) the post-operative state among others is characterized by an increased clotting tendency; (3) the treatment of acute thrombo-embolic phenomena requires massive doses of heparin but doses are frequently insufficient; (4) the prophylactic use of anticoagulants requires far smaller doses and overdosage readily occurs; (5) the need for simple, standardized methods of anticoagulant therapy is obvious—bedside tests for control are preferable to delicate but often unobtainable laboratory determinations; (6) the response to anticoagulants varies in different patients in different age groups and in the same person in different circumstances. Dicoumarol effectively reduces the prothrombin level, but the correlation between a safe level on one side and hæmorrhagic or thrombo-embolic complications on the other is poor. Since no safe anticoagulant for oral administration exists as yet, treatment with intramuscularly given heparin should have at present the widest field.

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Miscellaneous

Laryngeal versus Gastric Cultures in the Detection of Tubercle Bacilli. M. DUGGAN and LAURA DELAMATER, Brandon, Manitoba. *Canadian Medical Association Journal*, 1950, lxii, 54.

One hundred patients in the Brandon Sanatorium were examined in order to compare the efficacy of laryngeal swabs with that of gastric cultures in the diagnosis of pulmonary tuberculosis. By virtue of the greater comfort of the patient and its technical simplicity, it was felt that the laryngeal swab was preferable to the more unpleasant and technically more difficult procedure of gastric lavage and culture—if it could be shown that these methods were of equal sensitivity. Three laryngeal swabs were collected within a maximum period of five days, only one gastric lavage being performed; 32 of the 100 cases were positive to the laryngeal swabs, 30 to gastric culture; the average time for the laryngeal swabs to become positive was 19·4 days, for the gastric cultures 21·1 days. The authors conclude that three laryngeal swabs are as accurate as, and simpler than, a single gastric lavage. Full technical details are given.

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