NEWS & NOTES

Letter to the Editor

Sir, –

ENT Outpatient Services

I read Charles Bulman's article in September 1993's edition with much interest. I appreciate that some of the content was intended to provoke discussion, and should appreciate the opportunity to make some observations.

Vertigo

I must disagree strongly with the observation that "there is no investigation of vertigo". Properly speaking, we investigate both vertigo and ataxia, and these two can be difficult to distinguish for the patient and family practitioner alike, unless a very careful history has been taken. Examination can be extremely useful, especially where spontaneous nystagmus is present. Bidirectional or vertical nystagmus points clearly to a central lesion, while rotatory nystagmus induced by the Hallpike positional test is, when accompanied by latency and fatigue, sufficient to make a firm diagnosis of benign positional vertigo, and to identify the side involved (that of the underlying ear at the time of the positive test). Now that operation to block the posterior semicircular canal has been shown to provide reliable cure in the small number of cases which do not resolve spontaneously, this information is especially useful. Ataxia may be demonstrated by Romberg's and Unterberger's tests, and by heel-toe walking, and certainly does call for imaging of the posterior fossa when detected. Audiometry may suggest a cerebellopontine angle lesion by demonstrating a unilateral sensorineural loss, and magnetic resonance imaging of the angle and VIIIth nerve will now identify the smallest of acoustic neuromata cheaply and easily. Incidentally, such neuromata are now diagnosed more frequently than once a year here, no doubt partly because of ready access to good quality diagnostic imaging. The numbers have increased fairly steadily, and our computer database (including meningiomas of the angle) contains seventeen tumours diagnosed in 1987-93 – 2.5 cases per annum. This is reasonable in the light of standard incidence figures of 1 per 100,000 population per year[1].

Multiple sclerosis can indeed present with rotatory vertigo, and I have encountered several such cases. There is often associated diplopia. Magnetic resonance imaging now provides useful confirmation.

Finally, otologists should not forget what they do automatically; accurate examination of the tympanic membrane will reveal a choesteatoma producing a fistula of the lateral canal. I have operated on several over the last few years, some of them presenting with intermittent or continual vertigo.

Lump in the throat

Although carcinoma of the postcricoid region and upper oesophagus is relatively rare, I can recall at least three cases of mine in the last eight years. Unfortunately, we have had a far higher number of pyriform sinus tumours, and these, too, commonly present with a sensation of a lump in the throat. Large laryngeal cancers, especially those of the aryepiglottic fold, may produce similar symptoms. Of course, the majority of those with globus symptoms have no sinister underlying pathology, but there is no alternative to careful examination of all cases. Investigation may also reveal reflux disease, treatment of which often relieves the globus sensation, which is probably due to reflex hypertonicity of cricopharyngeus.

Facial pain

I agree entirely that most chronic and recurring facial pain seen in our clinics proves not to be due to sinusitis. A useful diagnostic feature of sinus pain is its diurnal variation, probably related to rates of mucus secretion. Sinus pain is typically absent on waking, appears during the morning, reaches its zenith in the middle of the day, and is absent again or much reduced by nightfall. Cyclical headaches which do not fit this pattern, and are not associated with nasal symptoms (especially purulent rhinorrhoea) are most unlikely to result from sinus disease. In this situation, there is a respectable role for conventional sinus radiographs ordered from general practice. Although there is a problem with minor degrees of mucosal thickening and partial volume effects in the maxillary sinuses, producing false positives, a normal occipitomental film (if properly projected and penetrated) gives fairly reliable confirmation of healthy sinuses under these circumstances.

The association of facial pain with purulent nasal discharge must, however, make sinusitis the working diagnosis until proved otherwise by nasal endoscopy, and, where necessary, detailed imaging using the CT scanner in the coronal plane[2].

I hope that these observations may stimulate continued discussion of these most interesting topics.

John R. Cherry
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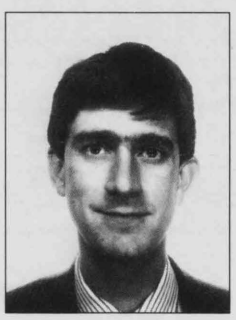
[1]. Ramsden, R.T. (1993) Vestibular schwannoma J. Roy Soc Med 86: 684-686

[2]. Stammberger, H. (1991) Functional Endoscopic Sinus Surgery. Decker, Philadelphia p.106

New Partner at Dalton Square Surgery, Lancaster



Neal Vaughan-Jones is one of the new partners at Dalton Square Surgery. Originally from the Welsh Marches/ Shropshire, he graduated from Birmingham in 1985. Having spent some time in hospital medicine in different parts of the country he rounded off his training with general practice experience in West Yorkshire. Exposure here to the attractive lifestyle that north England market towns offer, led to him applying for the post vacated by J. H. Chippendale in January 1993.

An elective spent studying the anthropology of Highland Indians in Central Mexico stimulated a continuing interest in the history and culture of Latin America. Whilst in the midst of his training he and his wife, took six months to explore Guatamala, Equador, Boliva and Pategonia.

He is married with a two-year-old daughter, Hannah, and a baby son Tom.

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