LETTER TO THE EDITOR

TO THE EDITOR, *The Journal of Laryngology and Otology.*

DEAR SIR,

In the May, 1949, issue of this Journal you published a clinical record by Mr. J. Evans. This is full of inaccurate statements, and it is quite clear that he does not realize the elementary factors involved in otitic barotrauma. I cannot see why the vertiginous attacks are ascribed to the caisson accident twelve years previously. None of the facts published establish this connection. Furthermore, the clinical observations are of doubtful accuracy, for the audiogram shows normal hearing for air and bone conduction in the right ear, yet he is said to have a negative Rinne in that ear, i.e. bone conduction better than air conduction. I assume that the air and bone conduction audiograms were masked for the left ear and therefore have some meaning. If they were unmasked this audiogram presents no evidence of any hearing in the left ear, and both may well be shadow curves. If they were adequately masked the left ear is preponderantly a conduction deafness and therefore its origin is unlikely to have been associated with his vertigo which came on twelve years later. The suggestion is that the patient had a conduction deafness originally and twelve months before examination he developed Ménière's disease (hydrops of the labyrinth) which accounts for the drop in his bone conduction audiogram. It would have been interesting to know on which side he lateralized his Weber when first examined.

Otitic barotrauma always presents itself during descent, i.e. with a rising barometric pressure. With a falling pressure the opening of the eustachian tube is automatic, and for this reason it is compared to a flapper valve. Hæmorrhage is a late stage in the barotrauma, and it is not accurate to say that the lesions are generally due to hæmorrhage. When ascent is made in a caisson the pressure falls and it is impossible to damage the ear with the barometric pressure. If the eustachian tube had been impermeable the pain on *descent* in the caisson would have been severe and the patient would have stopped his descent. Reascent would have relieved his pain. It can therefore be assumed that it was not barotrauma from which he suffered when the caisson was raised too quickly. He could have suffered from the "bends" which is an entirely different condition.

Finally Wright is misquoted. He emphasized that Ménière's disease may start in the cochlea, not that it invariably started in the cochlea.

I suggest that in view of these inaccuracies all the statements made in this record should be carefully scrutinized before being accepted.

I remain etc.

Yours sincerely,

GEOFFREY H. BATEMAN.

55 Harley Street,
London, W.1.—June 8th, 1949.