BRITISH MEDICAL JOURNAL

SATURDAY 20 JULY 1985

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NEWS AND NOTES

SUPPLEMENT

NO 6489 BRITISH MEDICAL JOURNAL 1985 VOLUME 291 159-230
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 291 (6489) 159-230 (1985)

CORRESPONDENCE

Because we receive many more letters than we have room to publish we may shorten those that we do publish to allow readers as wide a selection as possible. In particular, when we receive several letters on the same topic we reserve the right to abridge individual letters. Our usual policy is to reserve our correspondence columns for letters commenting on issues discussed recently (within six weeks) in the BMJ.

Letters critical of a paper may be sent to the authors of the paper so that their reply may appear in the same issue. We may also forward letters that we decide not to publish to the authors of the paper on which they comment.

Letters should not exceed 400 words and should be typed double spaced and signed by all authors, who should include their main degree.

Glue ear: the new dyslexia?

SIR,—When I started in practice in the early 1950s "Ts and As" were, and had long been, all the rage. The operation was related to social class, being more common in children receiving, or due to receive, private rather than state education. A cynic coined the phrase "chronic remunerative tonsillitis." Being unhappy about the whole business, I was in a receptive mood for John Fry's *The Catarrhal Child* in 1961, a marvellous combination of simple clinical observation and common sense. I realised that the waiting list ensured that a significant number of children referred for tonsillectomy and adenoidectomy eventually had their operation at just the time when the catarrhal stage was undergoing spontaneous resolution. Thus the operation received its justification. My referral rate of children aged under 10 fell from a figure I prefer to forget to an average of one a year or less. My referral rate for adults remained the same.

Parents were nearly always receptive to the concept of the "catarrhal stage of childhood" and its almost invariable spontaneous resolution. My suspicion that the catarrhal stage occurred earlier in first than in subsequent children was never properly tested; but I was sure that the children as a whole were no less healthy and happy for keeping their tonsils and adenoids. Then glue ear came in. We were told it was something new, something different. But as glue ear came in, catarrhal otitis (like the tonsillectomy graphs in Dr Nick Black's paper (29 June, p 1963)) faded away. Some ENT surgeons talked of an epidemic and, predictably, blamed the general practitioner for using antibiotics too often, too rarely, or in inadequate dosage. One surgeon, I recall, insisted repeatedly that every attack of otitis media demanded one million units of intramuscular penicillin twice a day for seven days. I never met a general practitioner foolish enough to take his advice.

Unlike "catarrhal stage," glue ear was a frightening phrase that demanded rather than suggested immediate intervention. New techniques showed fluid levels and immobile drums. Pressure from parents, health visitors, school nurses, and teachers increased. Recently I heard on the radio an electronic simulation of what the child with glue ear hears, or rather doesn't hear. Whether it was true or not I do not know; but it was certainly emotive. Grommets were put in ears. Some fell out; most stayed in. Looking at them through the magnification of an auriscope I wondered silently how they were able to let fluid out or air in if the far side was in contact with glue; and I wondered what their long term consequences were.

It would be foolish to say that surgical intervention for cararrhal otitis/glue ear should never be carried out. But the possibility should be considered that it may appear to our successors as venesection in the first half of the nineteenth century appears to us today—occasionally beneficial, but done a bit too often. Dr Black is to be congratulated for his disturbing paper. Perhaps it may have the same effect as one published some 30 to 40 years ago. I forget the author but remember the title: "The fate of the foreskin." It led slowly but relentlessly to the abandonment of almost routine circumcision of small boys and to the rational use of a sometimes necessary operation.

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SIR,—The article by Dr Nick Black on glue ear was certainly provocative and should generate a suitably heated debate. Quite correctly, he states that "glue ear" (secretory otitis media) has been described and treated with varying amounts of success at least since Astley Cooper's day. Holt and Harner described the techniques used by an earlier generation of ENT surgeons to bypass the blocked eustachian tube,[1] and it is only in recent years that suitable tympanostomy tubes have been produced which can be relied on to stay in situ for a reasonable length of time. The availability of these devices is sufficient to explain the present enthusiasm for "grommeting," simply because of the ease by which success—that is, relief of deafness and earache—can be predicted. It is partly because of these symptoms that patients are referred and treated.

Dr Black makes the valid point that in educated middle class circles adenoidectomy, and insertion of grommets, is as fashionable an operation as adenoidotonsillectomy was 30 years ago, the only difference being that the latter operation was directed against "focal sepsis," a term long ago consigned to medical archaeology, whereas the