

meatus is borne in mind, and the appropriate textbooks usually give clear instructions on the technique. A sterile nozzle is most important, as it is this part of the syringe which may traumatize the skin and introduce infection. Hard wax adherent to the skin should always be approached cautiously. It should be carefully eased away from the skin at one point, and the Jobson Horne loop and probe is an excellent instrument for the purpose. By carefully working round the periphery it may be possible to remove the plug as a whole. Otherwise, careful syringing into the gap between the meatal wall and the wax plug is often effective. The lotion goes inwards to the tympanic membrane, from which it rebounds and expels the plug outwards. The procedure is not without risk, as some degree of force is occasionally needed. The pressure exerted by a finger-operated syringe can rarely do any harm, but mechanically operated irrigators must be used with caution. A normal tympanic membrane stands a fair degree of pressure, but a thinly-healed old perforation may give way. It is therefore prudent to get a good history from any new patient. The syringe nozzle must always be under strict control and never forced into the meatus, as it may thereby damage the meatal wall or even the tympanic membrane itself or push the wax plug into it. In fact, it is often best to soften hard plugs with ear drops of plain glycerin for a few days before attempting removal, and if there is still some difficulty to refer the patient for specialist management. The lotion used in syringing can be plain water, if normal saline is not available, but it should always be sterile. A cerumenolytic lotion or oil would be a useful weapon, but in spite of many claims no preparation more effective than glycerin has yet been made.

The removal of wax plugs is essential, as sooner or later a skin reaction will occur ranging from a mild eczema to acute furunculosis. Fortunately, the procedure is usually simple, but there are difficult cases which demand considerable technical skill.

¹ Matsunaga, E., *Annals of Human Genetics*, 1961-2, 25, 273.

² Petrakis, N. L., *et al.*, *Nature*, 1971, 229, 119.

Anxiety of Patients in Research

A recent report from A. H. Schwartz, of Yale University,¹ draws attention to an odd and somewhat disturbing situation. It is a fundamental principle of medical ethics that informed consent must be sought and obtained from any person before he is subjected to a research procedure. This was embodied in the World Medical Association's Declaration of Helsinki in 1964² and is the basis of the guidance given by the Medical Research Council³ for any procedure which is of no specific benefit to the individual and may carry risk of harm. When true consent cannot be obtained, such a procedure should not be performed unless it is incidental to and does not alter the nature of a procedure intended for the individual's benefit. According to the Yale report the attempt to obtain true consent to a research procedure resulted in "overwhelming anxiety" in five of 19 children between the ages of 11 and 18.

The experience of overwhelming anxiety must be considered harmful. Therefore the attempt to obtain true consent becomes in itself a procedure which is of no particular benefit to the individual and may carry risk of harm. It

follows that the individual must give his consent for an attempt to be made to obtain his true consent to the research procedure. This is clearly a nonsensical situation. The Yale findings should be thoroughly studied, for they deserve careful thought.

The research procedures required admission to a special research ward in hospital. Most of the patients were being investigated for short stature, and at least one had emotional problems about his disability. The preparation of each patient for the research studies in hospital included at least two joint interviews with the child and his parents, a visit by the child and his parents to the research ward in the company of the medical investigator, and advice from a social worker to the parents about how to prepare the child. Interviews with the investigator began from six months to one year before admission. Whether the length and intensity of the preparation may have worried some of the children is worth considering, for they might be expected to feel some uneasiness about a procedure which was thought to require so long a preparation. Is it possible that we can strive too hard for understanding and consent, and that this may have resulted in the anxiety that was noted in five of the patients? Yet of the 14 children who did not experience overwhelming anxiety only one showed awareness that his stay in hospital was in any way connected with research, so it seems unlikely that the explanations about research were excessive.

If these findings result in the loss of adolescent patients for research procedures of no direct benefit to the individual, some interference with research into the special problems of that age group may result—but how much is worth considering.

Most investigations appropriate to teenagers could probably be carried out on young adults. What is more disturbing is the possibility that the findings may apply to adults too. Schwartz's report will no doubt stimulate similar studies in older people, and medical men will be justified in awaiting the results of such work with concern as well as interest. There will be compelling obligations on them to take them fully into account.

- ¹ Schwartz, A. H., *New England Journal of Medicine*, 1972, 287, 589.
- ² British Medical Association, *Members Handbook*, p. 60. London, B.M.A., 1970.
- ³ Medical Research Council, *Report for the Year 1962-3*, Cmnd. 2382, p. 21. London, H.M.S.O., 1964.

Hemifacial Spasm

Idiopathic hemifacial spasm, sometimes called clonic facial spasm, is a benign but troublesome condition in which recurrent contraction occurs in the muscles supplied by one facial nerve. It usually begins in middle age but has been described in adolescence.¹

The condition generally affects first the orbicularis oculi, giving intermittent twitching of the muscles round one eye, but subsequently the twitching spreads to the muscles of the upper lip and eventually to all of those on one side of the face. Frequently the disorder is mild and may remain so for many years, while spontaneous remissions have occasionally been observed. But in other cases the twitching becomes progressively more severe, with resultant discomfort and increasing embarrassment. The spasms are not rhythmical but occur irregularly. They are easily distinguishable from

psychogenic facial tics, with which in the first instance the condition is most often confused. Often the movements continue during sleep, and it is characteristic that they are accentuated by tension and anxiety. In some cases, after many years, some facial weakness ensues on the affected side. Pain accompanying the spasmodic movements is rare.²

The cause of the condition is often unknown, though an identical syndrome can rarely be a symptom of neoplasm in the cerebello-pontine angle,³ aneurysm of the basilar artery,⁴ or arachnoiditis of the posterior fossa.⁵ Sometimes the condition also occurs as a sequel to Bell's palsy, though more often in cases of the latter condition showing incomplete recovery fixed facial contracture rather than spasm occurs. Electromyographic recording from the affected facial muscles usually shows groups of two or three motor unit action potentials recurring spasmodically in time with the spasms, and this finding has been interpreted as indicating a state of chronic irritation of the facial nerve. K. J. Zülch⁶ has reviewed the evidence for its aetiology in detail and has concluded that the condition probably results from an unusually narrow facial canal, which causes slight but lasting damage to the nerve, with formation of an artificial synapse at the point of compression and thus to permanent irritation. He admits that the lesion so postulated has not been confirmed histologically, but the occasional occurrence of the condition after incomplete recovery from a Bell's palsy does give some support to this view, as does evidence indicating that in some patients surgical decompression of the affected facial nerve in the Fallopian canal produces considerable improvement in the spasm.⁷ T. Cawthorne⁸ operated on 13 cases. The operation was followed by facial paresis lasting for a few weeks, but the spasms ceased, and as facial movement recovered they did not return in some cases for as long as 18 months. Others have found this procedure less successful. Thus J. M. Curtin¹ noted that the spasms ceased in less than half his patients. Miehke⁹ suggested as an alternative method that 50% of each of the main branches of the nerve should be divided at the first point of branching after leaving the stylomastoid foramen, and H. Diamant and colleagues² operated on four patients, using this technique. These authors found that all patients developed some degree of facial palsy, and, though the spasms returned as this recovered in three cases, they were not so severe as before in two of them.

J. Potter¹⁰ has now reported on two patients treated by selective division of *terminal* branches of the facial nerve. These were located by making a vertical skin incision at the anterior border of the masseter just below the malar eminence, separating the subcutaneous tissue by opening out artery forceps in a horizontal plane, and detecting the fine nerve twigs by use of a facial nerve stimulator coupled to a diathermy needle. Small filaments, which when stimulated produced contraction of the lower part of the orbicularis oculi and elevation of the upper lip, were then divided. In his two patients there was no detectable facial palsy after the operation, and he attributed this finding to the anastomoses which occur between terminal branches of the facial nerve and to the fact that the muscles concerned are also supplied by the lower buccal and zygomatic branches of the nerve; yet the extent and severity of the spasm were substantially reduced. The duration of follow-up was relatively short at the time of writing, but it seems that the technique of surgical treatment which Potter described would be worth an extended trial in further cases. As already stated, the condition is so benign and self-limiting in many patients that simple sedative treatment with diazepam or similar remedies is often successful in damping down the movements sufficiently to render them

tolerable. But in those few patients in whom the movements become so severe as to constitute a major embarrassment surgical treatment deserves serious consideration.

- ¹ Curtin, J. M., *Proceedings of the Irish Otolaryngological Society*, Tenth Annual Meeting, 1969, p. 23.
- ² Diamant, H., Enfors, B., and Wiberg, A., *Laryngoscope*, 1967, 77, 350.
- ³ Cushing, H., *Journal of Nervous and Mental Disease*, 1916, 44, 312.
- ⁴ Campbell, E., and Keedy, C., *Journal of Neurosurgery*, 1947, 4, 342.
- ⁵ Laine, E., *Revue Neurologique*, 1948, 80, 38.
- ⁶ Zülch, K. J., in *Handbook of Clinical Neurology*, ed. P. J. Vinken and G. W. Bruyn, vol. 8, p. 277. Amsterdam, North-Holland Publishing Company, 1970.
- ⁷ Woltman, H. W., Williams, H. L., and Lambert, H. H., *Proceedings of the Mayo Clinic*, 1951, 26, 236.
- ⁸ Cawthorne, T., *Archives of Otolaryngology*, 1965, 81, 504.
- ⁹ Miehke, A., *Langenbecks Archiv für klinische Chirurgie*, 1961, 298, 923.
- ¹⁰ Potter, J., *Journal of Laryngology and Otology*, 1972, 86, 889.

Liquor Licensing and Public Health

The Report of the Departmental Committee on Liquor Licensing¹ (chairman, Lord Erroll of Hale) appeared last week and has had a mixed reception. This is doubtless because most people enjoy an alcoholic drink at some time but all are aware that the abuse of alcohol is a considerable public health problem. In fact there is uneasiness about what is believed to be its increase in recent years. Certainly there is evidence in the report that the consumption of alcohol is increasing. The consequences to health should be the first consideration of Parliament when it comes to consider whether the law needs to be changed.

Among the report's main recommendations is one that pubs should, at the discretion of the licensee, have the right to stay open for any part or all of the hours between 10 a.m. and midnight; the statutory afternoon break would be abolished. The age limit for drinking alcohol at the bar would be lowered from 18 to 17. The most radical suggestion relates perhaps to the notion of the "café pub," which is envisaged as an institution where coffee and snacks could be served as well as alcohol and as being a place where mother and father could take along their children of any age.

These and other suggestions are made against a background of statistics of which the committee was aware and which indeed find a place in its report. In Britain the average consumption of both beer and spirits per person has shown an annual increase for every year since 1962, while consumption of wine has been steadily increasing since 1965. The committee accepts the probable validity of evidence² which suggests that any overall increase in national drinking is associated with an increase in the number of heavy drinkers rather than simply with the recruitment of a greater number of moderate drinkers. It notes that the rate of arrest for public drunkenness per head of population has been increasing each year since 1967, with the rate among young people aged under 18 rising by over 50% during the course of five years. The report also presents data on post-mortem levels of blood alcohol among drivers killed in traffic accidents. The percentage of such victims with blood levels over 80 mg/100 ml is now back to the 25% before the breathalyser was introduced, and the gains from the 1967 Road Traffic Act have in that respect seemingly been lost. The committee acknowledges the difficulties which beset any attempt to obtain an estimate of general rates of national alcoholism or to interpret any of the indices already in use. But it felt able to conclude that this country