deafness. In hospital audiometry will measure the loss and impedance audiometry will confirm the cause. Mastoid radiography will show haziness in a cellular process, but not intercellular destruction until later stages.

TREATMENT

The present treatment is myringotomy. This is performed under anaesthesia and with the aid of an operating microscope. The wax is removed, and in some patients a hard semi-transparent crust which adheres to and forms a cast of the tympanic membrane is raised and removed. This may be due to a leak of glue through the membrane which solidifies on its surface and is sufficient to cause considerable hearing loss. The drum is incised and the fluid, which varies in consistency from thin and serous to opaque and viscid, is withdrawn from the middle ear by suction. It may take a considerable time if the fluid is nearly solid, but aspiration continues until no further fluid can be found. Some surgeons routinely insert a grommet through the incision. This is a fine plastic tube whose purpose is to ventilate the middle-ear cavity, and it is usually extruded two months to two years later. After extrusion it may be lifted from the external meatus. While it is in place no water must enter the ear. In some cases the tube must be removed under a short anaesthetic. The incision heals spontaneously. Adenoids and

occasionally tonsils may be removed at the operation, and some surgeons do this routinely while others prefer to make this a separate procedure.

Hearing immediately improves, but recurrences are found in at least 15% of cases. It is not certain whether these are true recurrences or due to incomplete removal of all fluid, and it must be understood that glue may not be confined to the middle-ear cleft, but may be found in the mastoid antrum and cells which makes aspiration extremely difficult. Recurrences require further incision and aspiration, and some surgeons reserve the insertion of grommets for these occasions. Long-term results are satisfactory in about 80% of patients, but whether this is due to surgery or to the fact that glue is seldom found, for whatever reason, in older children is debatable.

Complications occur. Tympanosclerosis, shown by the appearance of chalk-like patches on the drumhead, may ensue, and possibly this is encouraged by grommet insertion. The sclerosis tends to invade the middle ear and cause some degree of permanent hearing loss, and it is very difficult to eradicate. Cholesteatoma may form as a result of breakdown in a retraction pocket, so that these patients must be followed up for a long time. Repeated recurrences of glue may indicate a reservoir of fluid in the mastoid cells, and this may be demonstrated radiologically by intercellular breakdown. It is treated by mastoid surgery when the cells are eradicated. The necrotic cellular material is shown on section to be a cholesterol granuloma.

For Debate . . .

Five-and-a-half-day ophthalmic ward

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In terms of finance and the quantity and quality of skilled staff the rising cost of medical technological advances is in danger of pricing medical care out of the market for some patients. To continue providing an ophthalmic service in this district, with a diminishing number of trained nurses, we decided to try closing the ward at weekends, and we wish to report the success of this experiment. The principle is applicable to ophthalmic units serving small populations and in larger units where many beds could be closed at weekends.

Weekend closure of wards is not new.¹⁻⁴ It may be done where admissions are for cold procedures (investigations or surgery) requiring not more than five days in hospital. Three-quarters of the admissions to this unit came within this category (see table). Gilkes and Handa⁵ surveyed the length of post-operative stay in British ophthalmic wards, and the wide variations reported make nonsense of any logical basis for post-operative care. For example—it is unnecessary for children to

spend more than one night in hospital after squint operations. In the USA this is often a day-case procedure.⁶

Patients with cataract may be discharged after two nights⁷ one night,⁸ or even operated on as outpatients.⁹ In this unit the interval between cataract operations has been gradually, and

Planned and emergency admissions to ophthalmological unit 1972-4

	1972	1973	1974
Planned admissions:			
Cataract extraction	86	60	85
Squint	73	79	60
Retinal surgery	22	19	14
Enucleation	8	9	4
Glaucoma investigation	17	16	9
Filtration	6	4	4
Lacrimal sac surgery	11	4	7
Plastic surgery (cysts, entropion, ectropion, symblepharon, dermoid, rodent ulcer)	13	4	5
Total	236	195	189
Emergency admissions:			
Iritis, corneal ulcers	21	16	10
Penetrating injury and intraocular foreign bodies	7	9	5
Traumatic hyphaema	16	10	14
Vitreous haemorrhage	2	2	—
Herpes zoster	7	5	6
Miscellaneous (orbital cellulitis, lid injuries, chemical injuries)	8	1	7
Temporal arteritis, Stevens-Johnson syndrome, drug allergies	2	1	1
Infections	3	4	3
Acute glaucoma	14	10	9
Total	80	58	55
Percentage of total admissions that were planned	75%	77%	77%

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safely, reduced from one week to one day, and patients admitted for bilateral surgery spend only five days in hospital. Scott¹⁰ recommends free and early mobilisation after retinal detachment surgery and if this is right in the ward, why not at home? Is it really advantageous, or necessary, for such patients to stay in hospital longer than 12 days, as seems to be the case⁵ in 55% of British units? Patients who have undergone trabeculectomy can usually be discharged on the fourth day¹¹ and the healing of the tiny incision required for prophylactic iridectomy cannot require longer observation if the anterior chamber has reformed and the pupil is mobile.

Planning admission within a period of five nights is possible for all these procedures. The longer-stay cases (cataract, filtrations, and retinal detachments) may have surgery at the beginning of the week, while short-stay or day cases (squint, lids, and lacrimal drainage procedures) are treated at the end of the week. Surgeons may have to consider tailoring the choice of surgical procedure¹² and details of technique* to allow shorter stays in hospital. They should also consider whether routine use of general anaesthesia really is to the overall advantage of the patient—for instance, in adult squints, cataracts, and glaucomas.

We believe that there are several advantages for a five-and-a-half-day week in an ophthalmic ward. Firstly, the patients like early freedom and a short stay. There is less chance of the aged becoming disorientated; they do not consider themselves ill and therefore readapt to their home surroundings more quickly and easily (thus easing the problems for relatives or social services). There have been no postoperative complications that could reasonably be attributed to earlier discharge. Secondly, the full-

time nursing staff appreciate the regular break at the end of a planned week's work, into which part-time staff can integrate more satisfactorily. Lastly, there must be some financial saving.

The only disadvantage has been the occasional need to borrow a bed on another ward for the weekend for emergency admissions, which, for a population of 200 000, average about one a week. Some of these patients do not require the weekend in hospital, while others, such as those who have been in road traffic accidents, often have multiple injuries and should be nursed in an accident ward.

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Contemporary Themes

Assessment of the obstetric flying squad in an urban area

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Summary

The experience of an obstetric flying squad in an urban area over one year was reviewed. Very few calls were found to be justifiable, and it is concluded that few if any circumstances in modern obstetric practice merit continuing the flying squad in the urban area.

Introduction

The obstetric flying squad was introduced in 1933 as the Bellshill Emergency Obstetric Service with the intention of creating a rapid and efficient "first aid" service for managing obstetric emergencies occurring outside hospital. It has developed into a comprehensive service covering the whole country, in

which each district is responsible for fielding a team capable of covering the local population at a moment's notice. In practice, this team usually includes an obstetric registrar, an anaesthetic registrar, one or more midwives, and an ambulance crew. In teaching hospitals an obstetric houseman and a student are often included so that they may gain experience.

Having worked with three such teams in different urban districts, we got the impression that most of these emergency calls turned out to be nothing more than minor problems which could have been sorted out through the normal channels of a visit by the general practitioner or admission through the casualty department. Bearing in mind the cost of the service and the domestic upheaval caused by removing key staff from their hospital duties, we decided to review the flying squad calls in our district over the last year.

District

The district under review is in South London and has an estimated population of 190 200. From 1 April 1974 to 31 March 1975 there were 2616 births to district residents (including 33 home confinements) giving a total birth rate of 13.75 per 1000 total population, a little above the average for England and Wales. Although some of these births were actually outside the district they were matched by rather more outsiders who were delivered in the district. Only emergencies

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