Adequate premedication was necessary. The operation was prolonged to two hours and twenty minutes. Awareness was confirmed by the patient’s ability to recall detail in a conscious manner occurring during the latter part of the operation. Mrs. J. was not experienced pain.

In the later cases, after induction of anaesthesia, the administration was carried out by the anaesthetist, but is it necessarily too late? I hope that no one will be misled into ignoring or underestimating the adverse effects of even a minor degree of conductive deafness on the education of schoolchildren at a vital period in their development, and the importance of audiometric testing and energetic treatment—I am, etc.,

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London W.1.

REFERENCES

4 Holborow, C. A., 18th Meeting of the Oto- laryngological Congress, 1967, 133.

Epidemic Giddiness and Hyperventilation

SIR,—I found your leading article on epidemic giddiness (22 February, p. 457) most informative, but was surprised to find your omitting anxiety as a possible aetiological factor. I have seen the latter followed by a period of hyperventilation,2 responding well to explanation, reassurance, and desensitization to the underlying anxiety-producing situations. Propranolol is a useful adjuvant in these circumstances.

Professor M. Roth (22 February, p. 489) describes many symptoms of hyperventilation including “dizziness.” I recently saw a woman who complained of “dizziness” of five years’ duration, and who had consulted 25 doctors, including a variety of competent specialists, none of whom had explained the mechanism of her symptom (hyperventilation) to her. Wahl3 justifiably describes the hyperventilation syndrome as one of the “commonly neglected psychosomatic syndromes.”4—I am, etc.,

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REFERENCES


Indications for Tonsillectomy

SIR,—I would have thought that it was relatively easy to understand the mechanics of a central mass of adenoids blocking the Eustachian tubes (1 March, p. 574). A central pituitary, when enlarged, may affect the optic pathway on either side—a small mass of adenoidal tissue may block the tubes. The problem is, of course, not so easy; and more commonly infected, and as, Mr. E. H. M. Foxen says (15 February, p. 442), not necessarily large adenoids cause Eustachian malfunction due to lymphatic stasis and mucosal oedema.1 The importance of adenoids is not so much that they give rise to acute otitis but that they are largely responsible for conductive deafness and secretory otitis media, often with no history of acute episodes of infection. In one very large series 3.5% of all schoolchildren were deaf to a level of 15 db. or more.2

I quite agree with Dr. M. J. Banham (1 March, p. 573), who quite rightly says that adenoids will regress, but five years of continuous or intermittent deafness must retard education, and not all these ears return to normal. If conservative treatment fails adenoids should be removed, and, in my opinion, the tonsils as well if, and only if, they are causing trouble. There is very good evidence that conductive deafness and secretory otitis are very common in children, but there is much controversy about whether they are due to Eustachian malfunction3 and that this in turn is very often due to adenoids, and will often resolve after complete adenoidectomy.

I hope that no one will be misled into ignoring or underestimating the adverse effects of even a minor degree of conductive deafness on the education of schoolchildren at a vital period in their development, and the importance of audiometric testing and energetic treatment—I am, etc.

CHRISTOPHER HOLBOROW.

London W.1.

REFERENCES

4 Holborow, C. A., 18th Meeting of the Oto- laryngological Congress, 1967, 133.