Epitomes

Important Advances in Clinical Medicine

Otolaryngology—Head and Neck Surgery

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The Council on Scientific Affairs of the California Medical Association presents the following epitomes of progress in otolaryngology. Each item, in the judgment of a panel of knowledgeable physicians, has recently become reasonably firmly established, both as to scientific fact and clinical importance. The items are presented in simple epitome, and an authoritative reference, both to the item itself and to the subject as a whole, is generally given for those who may be unfamiliar with a particular item. The purpose is to assist busy practitioners, students, researchers, and scholars to stay abreast of progress in medicine, whether in their own field of special interest or another.

The epitomes included here were selected by the Advisory Panel to the Section on Otolaryngology of the California Medical Association, and the summaries were prepared under the direction of Terence M. Davidson, MD, and the panel.

Guidelines for Managing Chronic Otitis Media With Effusion

EAR INFECTIONS IN CHILDREN result in substantial economic cost to society. Persistent middle ear effusions that result in conductive hearing loss are implicated in delays or permanent limitations of speech, language, and cognition. Otitis media is the most common illness diagnosed by office-based physicians for children younger than 15 years, and tympanostomy tube placement in children for recurrent acute otitis media or chronic otitis media with effusion is the most commonly performed operation in the United States requiring general anesthesia. Children younger than 3 years are in their greatest period of language acquisition and therefore have the most to lose developmentally from a persistent hearing loss.

Because of the economic and developmental effects of otitis media with effusion in children, the US Department of Health and Human Services has sponsored the development of a clinical guideline for treating otitis media with effusion in children. This guideline applies to children between the ages of 1 and 3 years with no craniofacial, neurologic, or sensory abnormalities. The target child is asymptomatic, without signs or symptoms of acute otitis media, yet has otitis media with effusion. Pneumatic otoscopy is the main diagnostic tool, with tympanometry suggested as a method to confirm the presence of an effusion. After six weeks of an effusion, the administration of oral antibiotics is a therapeutic option. Parenteral decongestants, antihistamines, and oral steroids are not recommended at any time to treat the effusion only. Adenoidectomy or tonsillectomy is not recommended at any time for the management of effusion. Signs and symptoms unrelated to effusion—nasal congestion, allergic disease, nasopharyngitis—are not addressed by this guideline. Environmental risk factors for otitis media should be controlled at all times.

After three months of effusion, the patient's hearing is assessed using techniques appropriate for the age of the patient and the availability of audiologic services. A 20-dB or worse bilateral hearing loss should be treated with antibiotics or bilateral tympanostomy tube placement. Children with an effusion for four to six months and a 20-dB or worse bilateral hearing loss should receive tympanostomy tubes in both ears. An audiologic assessment is appropriate whenever concern arises regarding a child's hearing status.

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REFERENCE

Stool SE, Berg AO, Berman S, et al: Otitis Media With Effusion in Young Children: Clinical Practice Guideline No. 12. Rockville, Md. Department of Health and Human Services, Public Health Service, Agency for Health Care Policy and Research publication No. 94-0622, July 1994

Benign Positional Vertigo

A PATIENT'S COMPLAINT of dizziness can be nearly as troubling to the physician as it is to the patient. Most forms of dizziness, however, can be diagnosed in the office based on the results obtained from a precise history and physical examination. Benign positional vertigo is one such disorder that can be readily diagnosed by primary care physicians. Furthermore, new insights into the pathogenesis and treatment of this disorder have allowed for the development of simple, office-based therapeutic maneuvers that are highly effective at eliminating positional vertigo.

The history of a patient with benign positional vertigo is that of true rotatory vertigo elicited by a rapid head movement in a nonaxial plane—such as rolling over in bed or looking up to obtain an item on a shelf. Patients will usually steady themselves, and the vertigo will resolve within seconds (usually <1 minute), although the patient may feel unsteady, nauseated, or frightened for a longer period of time. Although this classic history is diagnostic for this disorder, evidence for the diagnosis may be derived from the physical examination by the performance of the Dix-Hallpike maneuver. In this test, the pa-