

the People's Doctor

A MEDICAL NEWSLETTER FOR CONSUMERS
by Robert S. Mendelsohn, MD

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Ear infections...Tubes in ears...Ear noises



Dr. Robert Mendelsohn

Will an untreated ear infection cause deafness, or has science never proven a cause-and-effect relationship? Are tubes in the ears a safe and effective treatment for ear infections, or do they cause so many problems that the risks may outweigh the benefits? Is a ringing sound in the ears something a person has to "learn to live with," or can the cause of the ringing be found in the medications the person is taking? These are the questions I address myself to in this month's Newsletter, and I think the answers may surprise you.

Q

My 3-year-old grandson has a cold most of the time. He has had an ear infection on two occasions, and he has pressure from fluid on his ear drums right now.

Our pediatrician has been treating him with oral antibiotics, but he now feels the child has had enough of these. He thinks the trouble may be an allergy, so milk and citrus fruits have now been eliminated, but it makes no difference--my grandson still catches cold. The pediatrician now talks of surgery during which tubes will be inserted. Do you know anything of this procedure, and what do you recommend?--R.B.

A

Ear infections

Although ear infections are an everyday concern for pediatricians, the amount of good scientific information regarding treatment is incredibly meager. Doctors as well as patients are frightened that untreated infections will lead to deafness, yet a cause and effect pattern has never been scientifically established.

The tubes you mention have become very popular (1.2 million procedures done yearly) since people have learned the risks of tonsillectomy and adenoidectomy (now down from 1.2 million/year to 580,000/year). While this new operation, called "tympanostomy" has helped provide continued survival for ear, nose and throat specialists, there is little evidence that it does anything good for patients. Indeed, a British study demonstrates that when the "grommet" (the British word for these tubes) is inserted in one eardrum and not in the equally-affected other one, the hearing levels some months later are the same in both ears.

However, the eardrum with the grommet tends to develop a scar which may later lead to hearing impairment. This reminds me of another famous British study about a decade ago establishing that heart attack patients of equal severity who were treated at home had a slightly higher survival rate than those treated in hospital coronary intensive care units. (Ah, those British!)

If your doctor advises tympanostomy, ask him for his opinion on the British controlled study of those grommets. If he pooh-poohs that research, ask him to share with you the scientific publications so that you can make up your own mind.

If a high percentage of untreated ear infections were to result in hearing loss, the incidence of deafness in children would be staggering, since many ear infections are undetected by the mother, undetected by a physician, inadequately treated (since not all patients take the prescribed amount of medication), and often not checked afterward to see whether they have disappeared. In some school screening tests, when children with a loss of hearing acuity were tested some months later with no intervening treatment, they showed normal levels of hearing.

Food allergies are also suspect in this condition, and one important study conducted among Eskimos showed that bottlefed babies have a higher incidence of middle ear infections than do breastfed babies. It is not known whether this phenomenon is due to the constituents of the milk itself or to the position of the infant during feeding. If a baby takes milk lying down, it makes sense that milk may be easily pumped or pushed directly into the middle ear, setting up inflammation or infection. The pediatrician is on the right track in being suspicious of cow's milk, but if other allergies are suspected, it might take a Sherlock Holmes to find the offender.

In the future, we doctors may have to consider whether the entire panoply of therapy for simple ear infections (antibiotics, antihistamines, insertion of tubes, tonsillectomy) does not represent overkill for a condition that, except in malnourished children, is almost always self-limited.

Q Because my son has recurrent ear infections, my doctor has suggested putting plastic tubes in his ears. I'm worried about using this procedure, but I'm also worried about possible deafness if I refuse to allow the tubes. What is your advice?--D.R.

A Twenty-five years ago I was solemnly warned by my professors that untreated ear infections would result in deafness. For a long time, and just as solemnly, I transmitted this information to my patients, bar-
*Tubes
in ears* raging them with a multiplicity of antibiotics and, later, plastic tubes through their eardrums.

As the years passed, I learned that many of my patients--perhaps the majority--failed to take the antibiotic for the time period prescribed, and sometimes never got the prescription filled at all. The medical journals provided a label--"patient noncompliance"--for this kind of bad behavior, and drug company ads railed about noncompliance. I was surprised when my noncompliant patients (together with millions of other similarly "uncooperative" patients) failed to go deaf. As a matter of fact, they didn't have even a little hearing loss that would show up on a hearing test. For a while I explained this phenomenon by invoking the standard line all doctors are taught to recite to patients who get well without following the doctor's advice--"You're lucky."

However, the numerous "noncompliant, lucky patients" finally roused my own common-sense suspicions, and I was forced to relegate "You're lucky" to the storehouse of useless phrases in the catechism of the religion of modern medicine. (Other useless parts of the doctor's catechism include, "Just trust me," "What do you expect at your age?" and "You'll have to learn to live with it.")

Having thus lost my faith in antibiotics, it wasn't too long before I similarly lost my faith in the plastic tubes. So, for the past several years, I have recommended to my patients (and taught my students) that, with the exception of purulent infections (where the pus runs out of the ear), the best treatment consists of heated olive oil dropped into the ear canal together with liberal doses of whiskey (by mouth, of course) to alleviate the pain and allow everyone, the patient included, to get some sleep while the infection clears up all by itself.

No carefully controlled scientific studies have been done which demonstrate that antibiotics and tubes, with all their risks, are any better than olive oil and liquor. Therefore, each patient must decide for himself which doctor's advice to believe. Many of my colleagues continue to scare their patients into their brand of treatment. My own patients usually are more afraid of these treatments than they are of the doctors' threats. Meanwhile, neither their patients nor mine are going deaf.

Q I think you are misleading the public by saying, "Nobody's going deaf --with or without treatment [of ear infections]."

Without antibiotic treatment, ear infection can abscess, rupture the eardrum and dissolve the earbone, producing deafness. And that's without mentioning mastoiditis and brain abscess. If you are not aware of this, just review the medical literature prior to the antibiotic era.

Heated olive oil in an inflamed ear [as you advise] will just hasten an eardrum rupture which may take most of the drum away with it, requiring subsequent microsurgery for correction.

In my opinion, ear tubes are helpful when used judiciously. They are not used in acute infections but rather in recurrent fluid-filled ears to protect hearing while the underlying cause of the fluid is being determined. This is usually caused by an allergy or enlarged adenoids.--H.G.T., M.D. Professor and Chairman, Department of Otolaryngology, Tulane University Medical Center, New Orleans

A I am happy you wrote me. This way, my readers have an opportunity to see how controversial medicine really is, and how you and I--two physicians--can differ, even though both of us are specialists and both hold faculty appointments at prestigious university medical schools.

You think I am misleading the public, and I think you are misleading your patients. You believe in antibiotics and ear tubes, and I believe in heated olive oil. You think my treatment is dangerous; I think your treatment is even more dangerous. It seems we have reached an impasse.

But all is not lost. Being men of science, we have scientific methods for dealing with this kind of dilemma which is so common in modern medicine. Therefore, I recommend that we conduct a controlled experiment, but one which does not use historical controls as you mention in your letter. (Every responsible scientist knows the fallacy of

comparing disease in one historic era with another.) I think it is time for your eminent department, either singly or in conjunction with others, to mount a good study in which half the patients are treated your way, and half are treated my way. This should help us give all of our patients a proper prescription, not for the 1920's, but for the 1980's. You have access to money and resources, and I am willing to serve as a consultant to this research project and to share the outcome with my readers. I'll be waiting to hear from you. (P.S. I'm still waiting.)

*Update
on tubes
in ears*

Despite the fact that inserting tubes in the ears is now the most commonly performed surgical procedure in children, this technique should be used only after other therapies fail. Pediatric News, January 1981, quotes the director of the department of otolaryngology of Children's Hospital, National Medical Center, in Washington, D.C., as warning that tympanostomy tubes sometimes may be inappropriately used for treating acute or persistent otitis media (middle ear infection). Dr. Kenneth M. Grundfast points to the possibility of postsurgical infection, localized foreign body reaction, granulation, hyalinization, and tympanosclerosis after tympanostomy. Persistent perforation of the ear also can result, or the tube can be dislodged into the middle ear. Grundfast cautions that avoidance of water in the ears is very important if tubes are inserted. He advises that a child's age, intelligence, and desire to swim must be considered before it is decided to insert tympanostomy tubes.

Q For years, I have suffered from a ringing in my ears. At first, I thought this was caused by high blood pressure; both my parents had died from strokes. My doctor told me that it was something I might have to live with.

Over the years, the condition has gotten worse: Both my ears ring, and at times I think it will drive me crazy. When I catch cold, I can't hear a thing. A doctor gave me some pills to loosen my sinuses which he said were pressing on the nerve behind my ear. The pills help, but only a little.

Where can I go for help? I am 67 years old, and am otherwise in good health.--Mrs. F.T.

A So many people have written to me complaining of ringing in the ears that I wonder why medical schools spend so little time on this widespread phenomenon. The long list of conditions which can cause this symptom may include middle- and inner-ear infections; excessive smoking or alcohol; cardiovascular diseases including hypertension and arteriosclerosis; endocrine disturbances; and allergies.

*Ringing
in ears*

However, in these modern times when illness often is caused by treatment, you may wish to review, together with your doctor, any medications you are taking (your letter does not specify what those pills are) that are known to cause ringing of the ears. This list (by no means complete) includes aspirin; Indocin; the antibiotics Kantrex, streptomycin and Nebcin; vitamin A, sodium salicylate and quinine. Perhaps if one of the aforementioned treatments is the culprit, you won't have to "live with" your ringing in the ears after all.

Q I have had ringing in my ears for more than three years. Hearing tests have shown no abnormality, and the doctors I've been to say nothing can be done--I'll just have to live with it. But surely something can be done.

At times, I hear a very shrill sound that is terribly annoying; the ringing sound is constant. I take at least 10 aspirin a day for rheumatoid arthritis. The doctors say not very much shows up in the blood. I'd appreciate any help you can give me.--I.R.

A I can't believe your doctors haven't told you that aspirin, regardless of blood levels, is a major cause of ringing in the ears. Is this message loud and clear enough?

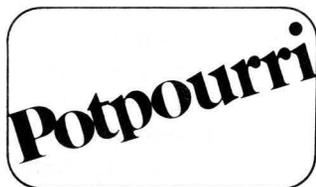
Q About a month ago, I developed a hissing in my ears, and my doctor gave me Arlidin. This medication didn't agree with me--it made me throb all over, including my heart--so the doctor said to stop using it. He could offer me no help other than Valium. Although he did say he could send me to an ear specialist, he also said such a doctor would only put me through tests before telling me I'd have to "learn to live with the problem."

Do you have any suggestions to offer? Valium doesn't seem to help, so I'm not taking it. Some days the noise is worse than on other days, and I don't understand why that should be the case.--Mrs. L.C.

A Why is it so much easier for a doctor to reach for a prescription pad to jot down a supposed cure than to reach for a book to find the cause? After all, the causes for tinnitus (ringing and other ear noises), clearly listed in the medical books, include infectious disease, high blood pressure and other cardiovascular diseases, Meniere's disease, obstruction of the Eustachian tube, endocrine disturbances, and allergy. The list of drugs causing tinnitus (Gantrisin, Dimetane, Dimetapp, Elavil, Garamycin, Lasix, Periactin, Sinequan, Talwin, Triavil) continues to grow. Large doses of quinine, streptomycin, aspirin and other salicylates, as well as cigarettes and alcohol may be responsible for this condition.

I am not surprised you developed that reaction from Arlidin (prescribed for circulatory disturbances of the inner ear) since the side effects of this drug include trembling, nervousness, weakness, dizziness, palpitations, nausea, and vomiting. And the list of side effects from Valium is even longer.

I suggest you say to your own doctor or an ear specialist in loud, ringing tones, "Before you next reach for your prescription pad, let's look for the cause."



Q Although I have always been anemic, this is no longer the case. I am 60 years old and living in a mobile home park in South Florida. Recently, a representative of the local blood bank came to talk to us and told us we "elders" were eligible to give blood as long as our health was good.

I decided it was time I contributed, and I did so two months ago with no problems. This week, I went to give blood again. When the nurse injected the needle to draw blood, she said my vein had moved, and she

had to re-do it. A few minutes later, she called another nurse, who said I was "vibrating." They had to stop the process, saying something about the blood clotting in the tube. They said I shouldn't give up on them, but should come back two months later to again give blood.

I never should have told my husband what happened, because he now is very nervous at the prospect of my again donating blood. The word "clot" has stuck in his mind and made him think "stroke." I told him the clot was outside of me, not inside.

What is your opinion about people my age donating blood? I'm in good health, have low to normal blood pressure, a slow pulse, no history whatsoever of illnesses. Is there any reason I should be cautious, or is my husband worrying needlessly?--F.R.

A

*Donating
blood*

No-one can oppose on humanitarian grounds the generous act of donating blood. However, the methods of blood collection and utilization often cause serious problems. For example, in our country, unlike others, paid donors are a source of blood. The incidence of infectious hepatitis in this kind of blood is so high that I recommend that every patient facing a blood transfusion ask his doctor whether he will receive volunteer blood or "bought" blood.

Another problem is the large amount of blood which must be thrown out for a variety of reasons, such as too much collected for use within the time limits. Add to this the internal political squabbles in the blood bank industry. Finally, there is the basic question of how much blood is used for unnecessary operations. I still am waiting for the first blood bank which will provide an honest report to blood donors stating the types of surgery for which their blood was used.

In your particular case, I presume you wrote for my advice because you do not trust the people in the blood bank who try to reassure you. I can understand your concern, since blood bank personnel obviously have a vested interest. I hope you will discuss this incident with your own doctor so that he may contact the blood bank to find out exactly what happened. You should return only if careful investigation reveals sufficient evidence to convince your husband that it is safe for you to again set foot inside the blood bank.

**Medical
News**

In a letter to the editor of the Journal of the American Medical Association (February 6, 1981), three doctors from Southfield, Michigan report a relationship between early childhood radiation therapy to the chest for asthma and later breast cancer. The physicians, Sheldon S. Stoffer, Stuart W. Hamburger, and Virgil R. Jefferson, explain that they are "studying a rather large group of patients who have had radiation to the head or neck area for a wide variety of reasons." These doctors point out that, although the relationship between radiation therapy to the head and neck area and thyroid cancer is well known, the same is not true for breast cancer. The three doctors caution, "It is less well-known and less well-publicized that some of these patients, particularly those that had radiation therapy to the chest for asthma, pneumonia, or because of an enlarged thymus, may have a greater risk of carcinomas of the breast developing."

I congratulate Drs. Stoffer, Hamburger, and Jefferson on their extremely important research findings. Those findings make it ever more important for patients to carefully question any doctor who wants to point an x-ray beam in their direction.

It seems to be a basic rule of modern medicine that one never discovers all the bad things about a medical treatment until a new one comes along to take its place. Take, for example, the case of slipped discs. Dr. Timothy B. Scarff, a neurosurgeon at Chicago's Loyola University Medical Center, recently reported on a new procedure he has developed which could help "an estimated 56,000 Americans each year avoid unsuccessful surgery for slipped discs."

Scarff points out that back problems frequently are misdiagnosed as slipped discs and that 20 per cent of patients who receive a myelogram (an x-ray of the spinal canal requiring the injection of a dye) will incorrectly appear to have a slipped disc. On the other hand, the myelogram will fail to discover this disorder in many patients who have the problem. Scarff also informs us that these myelograms and other procedures now used in the diagnosis of slipped discs are painful and risky.

If your doctor recommends a myelogram, ask him if he is familiar with Dr. Scarff's new diagnostic technique which involves the use of electricity. But make sure that your doctor closely questions Dr. Scarff in order to determine whether his new technique is any better or safer than the one Scarff criticizes. So far, Scarff himself reports his test has been found to be 93 per cent accurate. That means, of course, an error rate of seven per cent.

The following information (quoted in the Journal of the American Medical Association, January 9, 1981) comes from the first annual International Congress of Interferon Research in Washington, D.C. JAMA reveals the conference "had an air of upstage scientific excitement and backstage financial intrigue. With some of the biggest stars in the interferon research and business worlds crowded together in one hotel, it was difficult to mask the conflict with smiles and diplomacy."

You may recall that I have attacked in this Newsletter the premature claims of cure for everything from cancer to the common cold being made for this material which is contained within human cells. Here's what the interferon experts now have to say.

Charles Weissman, M.D., of the University of Zurich, Switzerland: "All of the excitement about it [interferon] is being brought back to earth. There are a whole world of experiments to be carried out."

Hans Strander, M.D., of Stockholm, Sweden, the first investigator to use interferon in a clinical study of cancer patients: "All we know is that interferon can affect the growth of human tumors in some patients, but in others it does not work. We do not really know why or how interferon works, nor do we know how to use it most effectively."

Meanwhile, the side effects already are beginning to surface. Interferon can cause fever, malaise, loss of appetite, increased blood pressure, and decreased white blood cell count. Moreover, according to David S. Secher, Ph.D., of Cambridge University, England, these effects are inherent and are not due to impurities in the batches of interferon (as had previously been believed). There is suspicion that, if interferon were given at very high doses, "The immune system might be affected adversely, possibly contributing to the development of other disease."

JAMA concludes that the investment of millions of dollars in research and production techniques by the National Cancer Institute and the American Cancer Society "may have prematurely raised public expectation."

If you thought that chemotherapy, irradiation, Krebiozen, radical surgery, and laetrile were controversial, wait till you step right up and see the "Great Interferon Show."

Another View

by Marian Tompson
President, La Leche League
International



When nodes developed on my vocal cords some years back, I was told to stop talking for two weeks to see if they would go away. Being silent turned out to be easier than expected thanks to my family's cooperation, but the reaction of outsiders with whom I came into contact shopping or running errands really surprised me. When I would hand them a note explaining my predicament, more often than not, they would start shouting at me or would turn to one of my children asking, "Would you please tell your mother...." Not being able to speak seemed to mean I also could not hear!

As funny as it seemed at the time, it did make me more sensitive to the awkwardness hearing and deaf people experience in their everyday encounters with one another. Wondering what might be done to make those encounters easier, I turned to Laurel and Jim Davies for advice. Jim teaches deaf teenagers in an Illinois high school, and his wife, Laurel, has had a 50 percent hearing loss since infancy.

"The first thing to remember when you meet a deaf person," Laurel began, "is that they are normal people and are not retarded. If their vocabulary is poor, this only reflects the limited opportunities they have to hear and to converse with others, and it is no indication of their intelligence level."

"Since a deaf person probably will use lip reading to help him understand what you are saying, be sure to face him as you speak and do not exaggerate your lip movements." Jim explained. "Exaggeration actually creates a different language. And since 90 percent of lip reading is guesswork, it might take a deaf person a while to figure out what you are saying. Shouting at him distorts the sound, making it more difficult to understand."

"If you are having difficulties you can always write it down on a piece of paper," Laurel suggested. "But relax; the deaf are experts at reading facial expressions, and if you look uncomfortable, they will feel uncomfortable. And if they ask you to repeat something, NEVER, NEVER dismiss it by saying that it's not really important. Just smile and repeat it, using the same kinds of words and sentence structure that you would use normally."

"In the minds of many deaf people, the fact that you can hear makes you special," added Jim. "Teenagers in particular often are reluctant to let you know of their hearing loss. Instead, they will smile a lot to conceal their embarrassment at not being able to participate in the conversation, and they will try to give the impression that they understand what you are saying because they fear impatience or rejection if they ask you to repeat something or if they are slow to understand."

Laurel agreed: "It took meeting Jim to make me feel secure enough to readily admit to others that I had a hearing problem. Knowing that he loved me as I was gave me the courage I needed to face any reaction others might have. I only wish there were more opportunities for those who can hear to learn fingerspelling and signing as a second language. They're not only fun to master, but it's a language you can practice without ever leaving town."

Male Practice: How Doctors Manipulate Women, Dr. Mendelsohn's latest book, has just been published by Contemporary Books (\$10.95).

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