To those unaware of the conditions of service in the regular Army this wholesale rejection of men who are found to be suffering from a perforated ear-drum, but who have adequate hearing, would seem to be an act of extreme folly to say the least, especially when it is taken into consideration that these men were found to be otherwise healthy and fit for enlistment. It has, however, already been shown how prevalent external otitis is among troops serving abroad. Given a tympanic cavity vulnerable to infection by virtue of an unhealed perforation, an infection of the tympanic mucosa occurs in the great majority of cases. This re-infection proves very resistant to treatment under tropical conditions and consequently a high percentage of those afflicted are invalided annually to the United Kingdom. This results in the loss of a great number of trained soldiers to the Army and a great financial loss to the State.

To a lesser extent the same consideration applies regarding service at home, in that re-infection of the tympanum in the presence of a perforation frequently occurs at bathing parades, which are a compulsory exercise, in spite of measures taken to prevent such an occurrence.

In conclusion, therefore, it is contended that conditions of service being what they are in the regular Army, which requires a man to be fit for service in any part of the world, the present aural standard should be adhered to and that, although it might be criticized as being too strict in its requirements, results have amply justified its adoption and retention.

"EARS" ON ACTIVE SERVICE.

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I shall confine my remarks, in the main, to ear conditions in an army on active service; if my thesis is maintained, details of army recruiting regulations for national emergency follow as a rational consequence. And I speak as a soldier—that is to say I do not regard a period of active service as a suitable occasion for the performance of operations and elaborate treatments proper enough in peace time. The function of a medical officer in war is to keep fighting units as near up to strength as in him lies.

I shall attempt to show that the prominence accorded to ear disease in the Army of 1914–18 was quite unnecessary and grossly exaggerated, and this was owing to the fact that medical officers were unfamiliar with the elements of otology and anticipated grave complications in all cases of otorrhoea. In any future national war we may look forward to a much more favourable state of things, for otology has now become compulsory for the qualifying examinations of the R.C.P. and the R.C.S., while the largely increased numbers of genuine aurists should supply an expert, at least, to every casualty clearing station.

The aural invaliding and recruiting crisis into which Major Hare and myself were detailed to inquire a few years ago was really a financial affair and somewhat different from our present problem, but certain points in Major Hare's results are worthy of special notice here. Of genuine ear cases, 90% of the men heard quite well on parade. In a certain year, India sent back invalided 404 ear cases. They were nearly all old perforation cases with mucopurulent catarrh set up by Service conditions, notably by compulsory bathing. It was then arranged that no man with a perforation should bathe without an ear-plug and a subsequent visit to the unit inspection room for the instillation of biniodide and spirit drops. The invaliding dropped to 13, and has remained thereabouts. The most important point for us in Major Hare's report is that if all applicants with ear trouble were rejected by the recruiting medical officer, we should lose at least 6%—he estimated at the time that the figure would be 10%
—of the total applicants. In recruiting on a national scale we cannot afford to reject anything like that percentage merely for ear trouble, nor is there any necessity to do so, as I hope to show. For pension purposes a record of aural defects should be made at the time of recruiting.

My own experience is that of an aurist with twenty years' civil hospital practice, acting for four years as an executive officer in a field ambulance, and therefore in touch with the fighting formations. In 1915 a field ambulance was a big affair, in our case (85 F. A., 28 Div.) occupying a great building, and alternately with one sister ambulance taking in all cases from half the Ypres salient, often from 400 to 1,000 a night, and retaining large numbers until their return to the firing line; for we had some first-rate surgeons and physicians among the officers.

After several months of this service I received an unofficial letter from the Statistical Office asking how I explained the enormous influx of ear cases to the base. I replied that I was amazed at the query, for I had seen no single ear case worthy of sending down the line—and the wet trenches round Ypres were no health resort!

At the end of 1915 the division went to the Balkans. There the field ambulance served 6,000 troops, often retaining 500 sick cases from start to finish; sending them back after convalescence to their units. During three years of that service we sent down exactly two ear cases—one, after a hurried glance, just before a battle, and one for vaccine treatment against recurrent furunculosis. Every day a corporal would be seen treating three or four cases of catarrhal discharge and sending the men off to their units with drops or powders, to return in a week; a loss to the force of say, twelve hours in all, spread over four weeks.

During a period of about six months, in the absence on sick leave of the throat-and-ear consultant, I went down to Salonika once a fortnight to help the eye consultant who had taken over the department. During that period I operated on one doubtful mastoid, a case which, as it proved, required no operation, but I did not care to leave it until my next visit.

I have related the four years' experience of active service in two remarkably unhealthy terrains—the experience of an aurist, that is to say, of a medical officer who recognizes in discharging ears the immense difference between an antero-inferior perforation and one in the postero-superior quarter. Is it too much to ask to-day, that every field ambulance should have one officer capable of making this easy distinction? Experience of 1917–18 tells us that we cannot afford in national emergency to reject recruits for slight defects, and all aurists will agree that old perforation cases under exposure will from time to time show a discharge which clears up in about three weeks, with the simplest conservative treatment in the case of antero-inferior perforations. Every civil out-patient room holds numbers of such cases daily, but the subjects do not dream of going sick and stopping work. Some such cases urgently need pharyngeal or nasal interference. In point of fact, I did not see one such case during the four years.

Also I would urge that there should be a genuine throat-and-ear specialist at each casualty clearing station. He will get very little important ear practice, but he can make himself quite useful in other ways. He can tie arteries and cut off limbs quite efficiently, and his experience of cranial surgery will probably exceed that of his brother officers. In the German push of 1918 I served in a C.C.S. in France for some weeks, and three or four head cases were detailed to my operating table every night. An aurist in a C.C.S. will prevent these mild ear cases getting past railhead to the base. I think all front-line medical officers will agree that once a man gets to the base they will not see him again for two months; he will come back soft, undisciplined, and lacking esprit de corps, and it will take a further three weeks for him to shake down again. The authorities need not fear aural pension troubles if records are taken in the recruiting office. Drumheads ruptured by explosion are best left strictly alone, while cochlear concussions gain nothing from the aurist.
Discussion on the Effect of Aural Conditions on Fitness

As I have been privileged in the past to advise the Army Medical Department on aural regulations for peace-time recruiting, may I make some suggestions for mass recruiting in national emergency?

That hearing of forced whisper at 10 ft., with the back turned to the examiner, should suffice for general service.

That an inspection of the drumhead should be made in all cases; an interval of half an hour should elapse after syringing for wax. The electric auriscope facilitates examination for medical officers unused to the forehead-mirror.

That a man with aural discharge, whether meatal or tympanic, should be directed to a civil hospital, to return in two months for re-examination.

That all candidates with dry perforations should be accepted for general service, provided the perforations are not in the postero-superior quarter.

That otherwise desirable applicants who have dry postero-superior perforations (i.e. free from granulations) should be accepted for permanent base (where they will do just as well as in civil life).

That in conservative mastoid cases with healed drums and at least six months' "dry" history, the men should be accepted for general service, and that in radical mastoid cases with twelve months' "dry" history, they should be accepted for permanent base.

That men with intact drums but with defective hearing, tinnitus, vertigo, or paracusis, should be examined by an aural specialist, as a precaution in regard to pensions.

That cases of atresia and of marked hyperostosis should be rejected.

That all functional or structural ear defects in men accepted should be recorded as a pension precaution.