

## Letters to the Editor

### How to make the invisible anterior tympanomeatal angle visible

Dear Sir,

Peltola and Saarento (1992) in their Short Communication propose a 'new method' to visualize foreign bodies hidden in the anterior tympanomeatal angle by administering water in the ear canal of the patient (who should lie on his back with his head tilted). While I agree that this trick does work I came up with a different explanation of how the water might assist in visualizing this commonly invisible area (Wind, 1984). I assumed – and still assume – that the water surface adopts a convex position rather than a concave one as Peltola and Saarento think. Also I mentioned that the oblique position of the surface relative to the optical axis of the microscope adds to the desired effect by obtaining refraction (cf. the oblique-stick-in-the-water effect). While it might be worthwhile to conduct some experiments to assess the (positive or negative) relative contributions of both mechanisms to the effect concerned, I do not believe that simply washing out the ear wax, as suggested by the authors, suffices to remove all the wax from the ear canal skin and so obtain the water surface adopting a concave shape.

Yours faithfully,  
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### References

- Peltola, T. M., Saarento, R. (1992) Water used to visualize and remove hidden foreign bodies from the external ear canal. *The Journal of Laryngology and Otology* 106: 157–158.  
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### Branchial cyst and cervical cystic metastases

Dear Sir,

In discussing the diagnostic confusion and difficulty between branchial cyst and cervical cystic metastases, Bath *et al.*, 1992, advocated endoscopy, ipsilateral tonsillectomy and blind biopsies of Waldeyer's ring, combined with excision of the cervical lesion in patients over 40 years old. They failed, however, to be clear whether that was applicable on every case of branchial cyst or cervical cystic metastases. If it was for the former condition, that may be considered indulgence in over, and unnecessary, investigation, and if it was for the second, we agree that it is appropriate to obtain blind biopsies, where the likely primary may exist even if this area is normal at endoscopy. In every case, however, the first step must be to

excise the cystic mass in the neck for histological examination with a comprehensive head and neck examination.

Cervical cystic metastases may indeed be misdiagnosed as a branchial cyst by the unwary because of its location, but it should not be forgotten that the only absolute proof of the nature of any cystic mass is its histological examination. The difficulty, however, would arise only if two conditions combine—first, an occult primary and second, a cystic degeneration in a metastatic node. This may suggest a tumour arising in a pre-existing branchial cyst (malignant branchioma). It is certain that the great majority of these tumours so-designated are metastases from a primary growth elsewhere (Willis, 1960). In such cases we feel that it is illogical to subject patients to ipsilateral tonsillectomy for the following—firstly, the source of occult primary can be anywhere in the different parts of Waldeyer's ring (Micheau *et al.*, 1990) and secondly tonsillectomy may not contribute too much to the whole outcome if these patients are treated as we advocate in a report to be published soon with a prophylactic radical course of radiotherapy to the whole region of Waldeyer's ring, in addition to removal of the cystic mass (El-Sharkawi and Williams, 1992).

Yours faithfully,  
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### References

- Bath, A. P., Murty, G. E., Bradley, P. J. (1992) Branchial cyst—to endoscopy or not. *The Journal of Laryngology and Otology* 106: 1006–1007.  
El-Sharkawi, A., Williams, G. (1992) Malignant branchioma—a further insight. *European Journal of Surgical Oncology* (accepted).  
Micheau, C., Klijanienko, J., Luboinski, B., Richard, J. (1990) So-called branchiogenic carcinoma is actually cystic metastases in the neck from a tonsillar primary. *Laryngoscopy* 100: 878–883.  
Willis, R. A. (1960) *Pathology of tumours*. Butterworth Medical Publishers, London, pp 235–306.

Dear Sir,

El-Sharkawi *et al.* (1992) fail to appreciate that it is in those patients over 40 years of age that we advocate unilateral tonsillectomy. To understand the rationale behind restricting it to that age group requires understanding of the aetiology of the two conditions, and we refer them back to our discussion (Bath *et al.*, 1992) with particular reference to paragraphs 1 and 6.

They further fail to appreciate that unilateral tonsillectomy is a diagnostic rather than a therapeutic procedure. We believe that the identification of the primary site where