A novel method of removing a foreign body from the external ear canal

To the Editor: A bewildered 7-year-old girl presented with a smooth plastic bead impacted into the right ear canal. On examination the canal was swollen, irritated and tender owing to previous attempts to remove the bead. The bead, measuring 4 mm in diameter, was pushed almost against the eardrum. A further attempt to remove the bead resulted in an agonised yell — further attempts to remove the foreign body were aborted. The parents were unemployed and could not afford private hospitalisation, nor did they own a car for transport to a government hospital. The patient was sent home for 48 hours to calm down before a further attempt to retrieve the foreign body. On her return a novel method was applied. The application stick of a cotton bud was amputated so that the cotton end was removed. A small amount of quick-setting super glue was applied to the amputated blunt end of the cotton bud. The glued cotton bud end was then carefully placed in contact with the plastic bead. After a few minutes the cotton bud stick was retrieved with the plastic bead attached to it.

The procedure was painless and the patient was discharged with the bead safely in mother’s hand.

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Book Reviews


Any book whose editors cheerfully admit that ‘reading a book is still more delightful . . . than . . . manoeuvring through PC menus’ evokes the sympathies of this crypto-Luddite reviewer. Digestive tract cancer accounts for more than one-third of all cancer deaths, and Springer has produced a comprehensive overview of these conditions. The book also functions as a valuable quick reference, with highlighted summaries, tables and algorithms. As always with Springer, the visual aspects are exquisite, with diagrams and colour pictures of remarkable clarity. Sadly, though, and notwithstanding the editors’ protestations of haste in production, a book published in 2004 should have more recent references — very few are later than 2001.

Scheppach, Bresalier and Tytgat have assembled a stellar constellation of authors, although even these have their blind spots. Spechler, writing on oesophageal cancer, is curiously vague on the strange and crucial epidemiology of the disease in its high-risk areas (South Africa, Iran, and China), while his management algorithm reflects the experience of the First World, rather than the grim imperative of the epidemic of advanced cancer so familiar in our situation.

Axon and Dixon dissect out the place of Helicobacter pylori in gastric adenocarcinoma; we wait to see whether the widespread use of eradication therapy for peptic ulcers (which has effectively eliminated surgery for benign disease) will alter the incidence of malignancy, although (if current models of pathogenesis are correct) this seems to be an unlikely hope.

The chapters on large bowel cancer provide extensive coverage of epidemiology, lifestyle risks, screening, and chemoprophylaxis, as well as a useful overview of the increasingly complex molecular genetics. But there is a curious blindness to the influence of surgical technique on survival (arguably the greatest single advance in rectal cancer in the last century), which confounds all the observations on the role of adjuvant therapy. A local recurrence rate after proctectomy of 30% is totally unacceptable in 2004, and definitely not ‘normal’; adjuvant therapy is not a substitute for doing the operation correctly. Surgery for rectal cancer needs to be centralised in specialist, high-volume units. There is also insufficient information on the place of radiotherapy, and the different modalities available.

The polyposis syndromes are admirably described, from genetic, pathological and clinical points of view; but readers need to be reminded that no surgeon would perform an ileo-anal anastomosis after a colectomy that leaves a residual rectum in situ.

Lynch on the Lynch syndrome is outstanding; this chapter alone justifies the price of the book. There is a clear précis of the confusing area of hereditary colorectal cancer, concluding with the entirely legitimate observation that since the risk of cancer in HNPCC is not significantly different from that in FAP, it is incomprehensible why prophylactic colectomy should be routine for the latter but controversial for the former.

Two authors from Mount Sinai (Croog and Itzkowitz) provide a thorough if conventional overview of cancer risk in inflammatory bowel disease, and acknowledge the problems of relying on dysplasia as the marker (not least of which is that no practising clinician that I know takes the required more than 40 biopsies at each surveillance colonoscopy) (four biopsies — one from each quadrant — 10 cm, and every 5 cm in the sigmoid and rectum). In addition, the significance of the clinical course on decision making, as well as Danish experience (no increased risk, because the colons had been removed on clinical grounds before they could develop cancer) are largely ignored.