B. Most episodes of glue ear are of short duration and resolve spontaneously.

In many children glue ear is transitory, however, many parents have no idea for how long the child had been experiencing symptoms. The average age at which many parents believe that the condition began is 22 months of age and usually there is considerable delay before the child is eventually being seen by the specialist.

C. There is large regional variation in rates of surgical treatment for glue ear.

Glue ear is not a glamorous disease and it is regarded as a minor problem. In most surgical specialities in the NHS, majority of patients are seen and treated by 'relatively inexperienced' junior medical staff in busy out-patient clinics, without adequate support of experienced audiologists, educational psychologists or speech therapists for a full assessment of a child. No doubt, surgeons take the easy option of entering child's name on the waiting list.

D. No single investigation can identify children most likely to benefit from surgical interventions.

The assessment of a child should include careful history, full clinical examination of the upper respiratory tract, age appropriate hearing tests and tympanometry.

The decision whether to operate or to wait should depend on the patient's age, speech development, symptoms, hearing level and the appearance of the tympanic membrane.

E. Hearing improvement after surgery is less than 12 dB and the effect of treatment diminishes with time.

Pure tone audiogram in young children is not always accurate or reliable. In some children the audiogram may be almost normal and yet the speech discrimination could still be impaired. Most normally hearing adults have no idea what an infant with 25–30 dB hearing loss actually hears.

F. A period of watchful waiting and use of a provisional waiting list may reduce surgery rates.

The most conservative treatment is careful follow-up of children, provided they are free from symptoms and do not have communication, educational or behavioural problems. However, most children by the time they reach the specialists for advice, have been waiting for months.

Children must be reassessed prior to an operation to make sure that the middle ear effusion is still present, however, the decision whether to insert a grommet or not should be made before and not at the operation.

G. Quality and Audit.

All established and organized departments should be following the recommended guidelines, assessing each case on its individual merits.

H. Cost.

Introducing watchful waiting and comprehensive assessment of each child by a team of experts has considerable implications in terms of finance and personnel.

I. Recommendations.

There is an urgent need of establishing uniformly good primary care facilities in local clinics and surgeries, so that only children with genuine needs are referred for specialist advice.

J. Research.

Whilst research in all aspects of management, including feed-back from the parents and children must continue, we must also remind ourselves that we are treating children and not the glue ears.

Medicine is not only about curing but it is also about palliation and caring.

N. Shah.

SURGERY OF THE EAR AND TEMPORAL BONE

Ed. Joseph B. Nadol, Jn and Harold F. Schuknecht. Raven Press. New York 1993. ISBN 0 88167 803 1. Price $206.50.

The common factor linking the many contributors to this book is an association with the Massachusetts Eye and Ear Infirmary. The Editors, who have also written a number of the chapters, have set out to produce a text which reflects that great institution's tradition of otological surgery. Certainly the influence and teaching of Professor Schuknecht is apparent throughout the text and most notably in the emphasis given to the underlying pathological processes present in ear disease. Without in any way diminishing the value of individual contributions, this book is very much a tribute to Professor Schuknecht's pioneering work and teaching.

The first six chapters of the book are devoted to the examination of the ear and include such topics as photography, imaging and the evaluation of the vestibular system and facial nerve function. The rest of the book deals with various aspects of ear surgery ranging from the treatment of auricular deformities through middle ear and mastoid surgery to tumour surgery and cochlear implants.

Each chapter deals with a separate topic. Operative techniques are described in a varying amount of detail but this is not simply a text book of operative surgery. Where appropriate the pathology of the condition under consideration is discussed as well as indications and contra-indications for surgery and the management of complications.

The operative techniques described are those that have been adopted and regularly used in the Massachusetts Eye and Ear infirmary. As this is one of the main purposes of the book it is not surprising that there is little mention of evaluation of alternative methods. In some chapters there is no specific reference to results. Although one can accept that the procedures would not be recommended if the results were not satisfactory, some statistical analysis of results for operations such as ossiculoplasty and tympanoplasty would have been helpful. Most of the chapters include a useful list of references ranging from 138 entries in the well balanced contribution on otitis media with effusion to a chapter with a single reference to the Author's own publication in 1973.

This is a handsome well produced volume. It is a pleasure to handle and read and the standard of illustration is excellent. It is an expensive book but not unduly so bearing in mind the overall high standard of the contents and the quality of the production.

Valentine Hammond.

COCHLEAR IMPLANTS AND DEAF CHILDREN

National Deaf Children's Society. Price £2 from N.D.C.S., 24 Wakefield Road, Rothwell Haigh, Leeds LS26 0SF. (Free to parents of deaf children).

Rather less than a decade ago the National Deaf Children's

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