LETTERS TO THE EDITOR

CLOSURE OF NEW ZEALAND CHAMBER

P.O.Box 35, Tai Tapu
New Zealand
28/9/94

Dear Editor,

SPUMS members should know that the operations of the recompression chamber in Christchurch, New Zealand, have ceased, either temporarily or permanently, on safety grounds. It is to be hoped that the service will recommence some time in the next few months, if the chamber is transferred to Christchurch Hospital and the facilities upgraded to meet modern standards.

However, this is by no means certain since Dr Alistair Gibson and I have been battling to achieve this for over four years without the various administrations that we have had to deal with in that time reaching any firm decisions. Recognition of the merits of this clinical service has been very difficult to achieve despite a wealth of data demonstrating its cost-effectiveness.

All enquiries regarding diving emergencies in New Zealand should now be addressed to the RNZN Hospital, Devonport, Auckland (09) 445 5922 or the Diver Emergency Service (NZ) (09) 445 8454

Michael Davis

DIVING AFTER ROUND WINDOW RUPTURE AND REPAIR

Suite 2, Gallagher House
37 Gordon Street
Mackay, Queensland 4740
25/10/94

Dear Editor,

I read with interest the letter entitled *Diving after round window rupture and repair* and the editorial response. It is of interest that this diver ruptured his round window during snorkel diving, which commonly produces this injury.

Whilst the reply is sound and logical, otologists will categorically state that one should never dive again following such injury and repair. To my knowledge there are no formal studies to substantiate this advice. However I understand that a pearl diver returned to diving after repair, ruptured his window again and nearly drowned due to the disorientation. I have seen a stapedectomised patient who was rendered profoundly deaf by barotrauma on a commercial flight. While in theory the repair of a round window rupture should be stronger than that following stapedectomy, the pressures involved in diving are considerably greater.

To my knowledge the senior naval ear, nose and throat doctors will absolutely ban further diving and I have no doubt they would categorically make this point if required to in a court of law. In the circumstances any diving doctor who does not comply with this view is taking a grave chance if medico-legal action arises because of their less than clear and forceful advice that divers with this injury should never dive again.

John Robinson
(ENT Surgeon)

BLACKOUTS AND DIVING

170A Richardson Rd
Mt Albert, Auckland 4
3/10/94

Dear Editor,

Recently I was consulted by a prospective diver who had been certified “fit to dive” by a colleague. However, the instructor was a little worried by the medical history, and sent him off for a second opinion.

For the last twenty years or so, about twice a year this man has had “blackouts” while he was awake. They occur without warning. He is unconsciousness for perhaps 30 seconds or a minute and is disoriented for a period afterward. I dissuaded the chap from diving, believing he had a total contraindication to recreational scuba diving.

However, this man’s risk of dying underwater may be acceptable. Assuming he is awake 5,000 hours a year, has two “blackouts” a year and dives last half an hour each, then he has about 1 chance in 5,000 of blacking out during any one dive. If his diving career lasts 30 dives (probably above the average for a recreational diver), his risk of a blackout during at least one of those dives is $1-(0.9998)^{30}$, or 0.006. If his career lasts 50 dives there is a 1% chance he will blackout underwater during at least one of those dives. If it lasts 100 dives, there is a 2% chance.

This man drives a car. It seems irrational to prohibit him from recreational scuba diving (as I did), while he continues to indulge in a far more risky activity, considering the hours per year he spends behind a wheel, compared to those he would spend underwater. Any thoughts?

Rhys Cullen