Part of the meeting will be devoted to a workshop on fitness for diving so that a New Zealand consensus may then be taken to the SPUMS ASM workshop later in the year. Original papers for a free papers session are now invited from members. We would also be very pleased to hear from New Zealand members of topics they would like discussed.

Enquiries should be addressed initially to
Dr Chris Morgan, 9 Amohia Street, Rotorua, New Zealand (phone (07) 347 8350);
the Secretary, Dr Rees Jones, Northland Pathology Laboratory, P.O.Box 349, Whangarei, New Zealand (phone (09) 438 4243; fax (09) 438 4737),
or the Chairman, Dr Mike Davis, P.O.Box 35 Tai Tapu, New Zealand (phone (025) 332218 or (03) 329 6857, fax (03) 332 8562).

SPUMS ANNUAL GENERAL MEETING 1995
will be held at
Castaway Island Resort, Fiji,
on Saturday June 27th at 1800.

Motions, in writing, for discussion at this meeting must be in the Secretary's hands by April 14th 1995. Allow at least a week, and preferably longer as letters have to be forwarded to Dr Meehan from the Australian and New Zealand College of Anaesthetists in Melbourne.

ANNUAL SCIENTIFIC MEETING 1995

Castaway Island, Fiji.

Sunday 21/5/95 to Sunday 28/5/95

The Guest Speaker is to be Dr A A (Fred) Bove, Chief of Cardiology at Temple University in Philadelphia. He was the Guest Speaker at Madang in 1982. The Convener of the ASM is Dr David Davies, Education Officer of SPUMS. The theme of the meeting is Fitness to Dive. The Workshop theme is Asthma.

Those wishing to present papers are asked to contact Dr Davies at Suite 6, Killowen House, St Anne's Hospital, Ellesmere Road, Mt Lawley, Western Australia 6050 (Fax 09-370-4541) as soon as possible. The same applies to those wishing to contribute to the Workshop on Asthma, especially if unable to attend the meeting. Dr Davies intends to prepare their written submissions to distribute to those attending the meeting. This means that such contributions will need to be in his hands by the middle of April 1995. Intending speakers are reminded that it is SPUMS policy that speakers at the ASM must provide the Convener with the text of their paper, ready for publication, before they speak.

The Offical Travel Agent for the meeting is Allways Dive Expeditons, 168 High Street, Ashburton, Victoria 3147, Australia. Telephone (03) 885 8863, Toll Free 1-800-338-239, Fax (03) 885 1164. From overseas dial 61-3-before the last 7 digits of the telephone and fax numbers.

LETTERS TO THE EDITOR

ROUND WINDOW RUPTURE

118 Remuera Road
Auckland 5
New Zealand
2/12/94

Dear Editor

There seems to be some confusion over this topic and I would like to correct some of the suppositions which occurred in the SPUMS Journal.[1,2] The first letter should have the short answer "that the diver can go back diving." The only provisos are that he should observe are those which should be taught to all divers. Such items as clearing the ears, slow feet first descent, slow ascent, no diving with a cold etc. This is all standard diving technique. The PADI Safe Diving Practices should always be observed.

Two items should be appreciated by those approving or disapproving a return to diving. The risk of a re-rupture of a round window membrane is low if the repair operation has been radically carried out. It is usual to use a relatively large plug of fibrous tissue usually temporalis fascia, to repair the membrane after removal of the epithelium of the round fossa and membrane. From experience with having a second look at the stapes after operations for otosclerosis, where temporalis fascia was used, quite a thick membrane occurs as the end result. However recurrences of round window ruptures after repair are reported in the non-diving population so there maybe some factor predisposing to re-rupture not related specifically to diving.

The second item is that the round window rupture is not randomly occurring in laterality. It occurs twice as often on the right side than on the left. Because of this laterality, there is in any person some reason that causes

TABLE 1

21 CASES OF ROUND WINDOW MEMBRANE RUPTURE

Cause		Treatment		Years diving since
Rapid descent	10	Surgery	14	4, 1, 6 ,1 ,16, 9, 1, 2, 12.
Difficulty in clearing ears	7	Medical	6	16, 14, 6, 1, 1.
None recorded	7	None	1	23.
Totals	24		21	Dived again 15

Repaired and never dived again	3	Medical treatment and gave up diving	1	No follow up	2

that particular ear to be affected. If there is to be a recurrence it will be in the predisposed ear, the one that has already been affected. Thus if deafness is a factor to be concerned about it will only be in that one predisposed ear. So the threat of total deafness should not be used as it would statistically be rare or in my guess 1 in a 100,000. Even with total deafness in 1 ear the NAL (Commonwealth National Acoustic Laboratory) Hearing Handicap is only 16%.

However before anyone rises to my contentious statements, there are rare cases of rupture of both left and right round window membranes at the same time. The only case I have been involved with was a member of a police diving team who after repairs of both ruptures retained normal hearing and was forbidden to dive in his profession, but carried on diving for recreation on my advice.

I have treated cases of round window rupture and I have never told the diver to give up diving. What I have said is that if they develop any further trouble they should telephone me as soon as possible for advice. This was what the diver with the crayfish in his ear did.[3] Two cases of repaired round window rupture have carried out over 10 years each of diving since the operation (Table 1). I have even operated on a diver who ruptured her round window membrane 3 weeks before she went diving.

Noel Roydhouse

References:

1 Fitzpatrick P. Diving after round window rupture. *SPUMS J* 1994; 24 (3:)144

2 Knight J. Diving after round window rupture. *SPUMS J* 1994; 24 (3:)144

2 Roydhouse N. Diver's ear pain or claws 2. *SPUMS J* 1988; 18 (1)**:** 32-33

AURAL BAROTRAUMA

Suite 2, 37 Gordon Street
Mackay, Queensland 4740

1/12/94

Dear Editor,

I wish to report a recent case of aural barotrauma from Hayman Island.

The 35 year old male undertook a resort course, and in his own words, was a little alarmed as was his wife at the number of disclaimers he signed before the dive. There was, as is usual, only a questionnaire and no formal medical examination.

The patient experienced severe pain at 3 m, continued to 9 m and then experienced unusual whistling noises on ascent. His ear remained painful the following day and he was referred to me.

I found the right ear had evidence of chronic otitis media in as much the incudostapedial joint was eroded and the drum adherent forming a myringostapedopexy. Bubbles of fluid were quite obvious in the middle ear. The left ear had both evidence of otitis externa and middle ear fluid. His nasal septum was grossly deviated to the left.

The patient insisted that he must fly back to England within 48 hours against my wish to treat the infection and barotrauma conservatively.

If I had seen this patient before commencing a scuba course I would have declared him unfit for diving, and explained why, on the basis of his chronic otitis media and gross septal deviation. It is not uncommon for barotrauma to arise in such patients who are relatively asymptomatic. Despite all the disclaimers signed, it is my view that the diving agency is culpable and I believe it is only good fortune rather than good planning, that is preventing the operators being sued.

I am aware of the numerous arguments about the needs for diving medical clearances but I must add my