If Dr. Whittaker stated that sudden hearing loss sustained while diving should be regarded as suspected perilymph leak, which should be treated as an emergency; he is absolutely correct. In my experience of 59 confirmed perilymph leaks, as determined by operation, only two perilymph leaks of the round window type presented with any history of vertigo. The only case of oval window fistula sustained while diving presented with severe vertigo and sensorineural hearing loss. I would also state that it is highly unlikely that a perilymph leak to occur on ascent or for there to be labyrinthine membrane rupture in a subject with normal eustachian tube function, as the eustachian tube opens, without requiring any muscular activity when the middle ear pressure reaches 100-200 mm of water. On rapid ascent the subject is exhauling and therefore is not usually consciously equilibrating the middle ear pressures. If Case Two had normal eustachian tube function, then her diagnosis must be decompression injury. As a rule of thumb, vertigo on descent, especially if preceded by otalgia means tympanic membrane rupture until proved otherwise. Vertigo and hearing loss after ascent equals decompression injury to the vestibule, and requires the use of a decompression chamber, or further descent and slow reascent if in the bendo. If recompression abolishes vertigo, diagnosis is vestibular bend, if unabolished, perilymph leak or labyrinthine membrane rupture.

I think that Noel Roydhouse has been dogmatic in his statements; in being so he has left himself open to criticism; as I have demonstrated in Case Two.

I am sorry that I have taken so long to reply, but I have been on leave and have had one or two problems in my fight to set up the definitive ENT Department at Mansfield; this as taken a fair amount of my time.

Anyway I hope that my comments will be of some use. By the way, would there be an opportunity to write an article for the BJSM on a topic, such as ENT problems in Diving and their management?

With kind regards,

Yours sincerely,

WILLIAM D. McNICOLL, FRCS(G), DLO

OBITUARY

Dr. Samuel Leonard Simpson, MD, FRCP

Within a few days of writing the obituary for Dr. J. B. Adams we learnt of the death on August 3rd of another founder member of our Association, Dr. Leonard Simpson, who died at the age of 82. This distinguished endocrinologist qualified in 1925, having first been awarded a double first in the Cambridge Tripos. He obtained the MD in 1930, having gained MRCP in 1928, and was elected FRCP in 1940.

His first interests were in diseases of the chest but after a stay at the Mayo Clinic he became interested in the new science of endocrinology; diabetes and later the steroid treatment of Addison’s disease. His book on major endocrine disorders became the definitive text for two decades. After the Second World War he was appointed Consultant Endocrinologist to St. Mary’s Hospital, Paddington, and as a colleague of our co-founder Lord Porritt, he was one of the small group of doctors who founded the British Association of Sport and Medicine. He was able to apply his sporting enthusiasm in boxing, riding, tennis and golf to the medicine of sport, particularly to its endocrinological aspects.

Apart from medicine, his connections with sport were extensive. On his brother’s death he became an active partner in the family’s world famous business, noted especially as sports outfitters, and became Chairman of the Company in 1957.

During the last few years, he was unable to participate in many BASM activities, but he gave us his support up to the time of his death. We extend the sympathy of this Association to his widow and to his daughter.

H. E. Robson