Volume 7

Advances in Otolaryngology–Head and Neck Surgery®

Myers · Bluestone
Brackmann · Krause

Advances in Otolaryngology—Head and Neck Surgery®

Volume 7 • 1993

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Mosby–Year Book, Inc.
11830 Westline Industrial Drive
St. Louis, MO 63146

Editorial Office:
Mosby–Year Book, Inc.
200 North LaSalle St.
Chicago, IL 60601

International Standard Serial Number: 0887-6916
International Standard Book Number: 0-8151-6265-0

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Volumes 1 through 5 (out of print)

Volume 6

Contributors

Andrew Blitzer, M.D., D.D.S.

Professor of Clinical Otolaryngology, Acting Chairman, Department of Otolaryngology, College of Physicians and Surgeons, Columbia University, Director of Otolaryngology Service, Columbia-Presbyterian Medical Center, New York, New York

Mitchell F. Brin, M.D.

Assistant Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University; Coordinator, Dystonia Clinical Research Center, Columbia-Presbyterian Medical Center, Columbia Presbyterian Medical Center, New York, New York

Patrick E. Brookhouser, M.D.

Director, Boys Town National Research Hospital, Father Flanagan Professor and Chairman, Department of Otolaryngology and Human Communication, Creighton University School of Medicine, Omaha, Nebraska

Stephen P. Cass, M.D.

Assistant Professor, Department of Otolaryngology, University of Pittsburgh School of Medicine, Pittsburgh, Pennsylvania

Jasper V. Castillo, III, MD

Resident, Division of Otolaryngology, University of Alabama School of Medicine, Birmingham, Alabama

Kenneth M. Grundfast, M.D.

Professor of Otolaryngology and Pediatrics, Division of Otolaryngology, Department of Surgery, George Washington University School of Medicine and Health Sciences; Chairman, Department of Otolaryngology, Children's National Medical Center, Washington, D.C.

Jeffrey P. Harris, M.D., Ph.D.

Professor and Chief, Division of Otolaryngology-Head and Neck Surgery, University of California, San Diego, School of Medicine, UCSD Thornton Hospital, San Diego, California

Jonas T. Johnson, M.D.

Professor and Vice Chairman, Department of Otolaryngology, University of Pittsburgh School of Medicine, The Eye & Ear Institute, Pittsburgh, Pennsylvania

Timothy M. Johnson, M.D.

Departments of Dermatology, Otorhinolaryngology, and Surgery (Plastic Surgery), University of Michigan Medical School, Ann Arbor, Michigan

James A. Koufman, M.D.

Director, Center for Voice Disorders of Wake Forest University; Associate Professor, Department of Otolaryngology, Bowman Gray School of Medicine, Wake Forest University Medical Center, Winston-Salem, North Carolina

Trevor J. McGill, M.D.

Associate Professor, Department of Otolaryngology, Harvard Medical School; Associate Otolaryngologist-in-Chief, The Children's Hospital, Boston, Massachusetts

Edwin M. Monsell, M.D., Ph.D.

Head, Division of Otology and Neurotology, Department of Otolaryngology–Head and Neck Surgery, Henry Ford Hospital, Detroit, Michigan

Bruce R. Nelson, M.D.

Departments of Dermatology, Otorhinolaryngology, and Surgery (Plastic Surgery), University of Michigan Medical School, Ann Arbor, Michigan

James S. Reilly, M.D.

Professor, Otolaryngology, Thomas Jefferson Medical College, Philadelphia; Chief, Pediatric Otolaryngology, A.I. duPont Institute, Wilmington, Delaware

Leonard P. Rybak, M.D., Ph.D.

Professor, Department of Surgery, Southern Illinois University School of Medicine, Springfield, Illinois

Kathleen Sie, M.D.

Assistant Professor of Otolaryngology, University of Washington; Assistant Otolaryngologist, The Children's Hospital, Seattle, Washington

Yvonne S. Sininger, Ph.D.

Director, Children's Auditory Research and Evaluation Center, House Ear Institute, Los Angeles, California

Michael H. Stevens, M.D.

Clinical Professor, University of Utah School of Medicine, Salt Lake City, Utah

Dean M. Toriumi, M.D.

Division of Facial Plastic and Reconstructive Surgery, Department of Otolaryngology-Head and Neck Surgery, University of Illinois College of Medicine, Chicago, Illinois

John Zitelli, M.D.

Shadyside Medical Center, Pittsburgh, Pennsylvania

Preface

Volume 7 of *Advances in Otolaryngology–Head and Neck Surgery* provides an interesting selection of topics that will have a wide appeal to all members of our specialty. The opening chapter by Andrew Blitzer entitled "Evaluation and Management of Hyperfunctional Muscular Disorders of the Head and Neck" brings us information about the wonderful advances in the diagnosis and management of some common and some very uncommon neuromuscular abnormalities. Advances in diagnostic methods and the use of the Botox vaccine is a major step forward in the management of these problems. Dr. James Koufman's chapter, "The Otolaryngologic Manifestations of Gastroesophageal Reflux Disease (GERD)," is a continuation of his studies on this problem and he outlines advances in the management of this disease with the very latest medications. Michael Stevens has written a very nice summary of what is known about the diagnosis and management of toxic shock syndrome in otolaryngology. There have been isolated case reports but Dr. Stevens is the only one who has set this down in a orderly and comprehensive manner and the chapter is full of information about the management of this dangerous problem.

For those interested in head and neck problems, Dr. Jonas Johnson has detailed advances in the management of deep infections in the head and neck. Although these problems are not as common as they were at one time, the mechanism of development of such problems as well as the treatment have changed over the years. Dr. John Zitelli, a dermatologist who trained with Dr. Mohs, has considerable experience in cutaneous surgery and outlines the advances in this field together with a summary of his extensive experience in his chapter, "Mohs Micrographic Surgery for Skin Cancer." Over the years, the management of rhabdomyosarcoma of the head and neck, particularly in children, has undergone a remarkable development that has resulted in vastly improved cure rates, particularly in early-stage disease. Dr. Trevor McGill reacquaints us with the role of the surgeon in the management of head and neck rhabdomyosarcoma given that chemotherapy and radiation therapy are now the mainstays for the management of many of these tumors.

The chapters written by Drs. Kenneth Grundfast and Patrick Brookhouser will appeal to those of our readers interested in pediatric otolaryngology as well as otology as they deal with the evaluation of sensorineural hearing loss in infants and children, and Dr. Grundfast's chapter points out new studies which will acquaint us with advances in the diagnosis of hereditary hearing impairment in children. The chapter by Drs. Reilly and Castillo on the advances in the management of airway infections in children will be useful to those with a particular interest in airway problems in children.

Dr. Dean Toriumi has presented a very nice chapter acquainting us with

the current status of rhinoplasty. Drs. Nelson and Johnson have written a chapter that summarizes very well the state-of-the-art in the management of androgenetic alopecia and makes very understandable an area that is quite complex.

Another cluster of chapters will appeal very much to individuals interested in otology. The chapter by Dr. Jeffrey Harris gives us excellent information about the advances in the new field of autoimmune diseases affecting the inner ear. Certainly this is an area driven by advances in technology and basic science and should be appealing for everyone interested in this area. Dr. Yvonne Sininger acquaints us with the clinical applications of otoacoustic emissions, the importance of which has been discovered in recent years. In their chapter, Dr. Edwin Monsell and colleagues acquaint us with the current status of aminoglycoside treatment for vertigo.

I want to thank my colleagues on our editorial board, Drs. Charles Bluestone, Derald Brackmann, and Charles Krause, for providing great help and guidance in selecting the topics and authors and in reviewing and critiquing the chapters. The fact that our editorial board has been able to maintain the high quality of these volumes together with an apparently never-ending variety of topics is a great tribute to their depth of knowledge in the field and an awareness of who are the active contributors in our specialty.

Barbara A. Sigler, R.N., M.N.Ed., our editorial coordinator, and Mary Jo Tutchko, my administrative assistant, should receive much of the credit for keeping the organization and production of this volume on time.

We welcome Diana Dodge who has succeeded Amy Reynaldo as assistant managing editor assigned to *Advances in Otolaryngology—Head and Neck Surgery*. We thank Amy for the outstanding job that she's done and welcome Diana who we're certain will be very important to our activities during her time in office.

Eugene N. Myers, M.D.

Contents

Evaluation and Management of Hyperfunctional Muscular Disorders of the Head and Neck

Andrew Blitzer, M.D., D.D.S.

Professor of Clinical Otolaryngology, Acting Chairman, Department of Otolaryngology, College of Physicians and Surgeons, Columbia University, Director of Otolaryngology Service, Columbia-Presbyterian Medical Center, New York, New York

Mitchell F. Brin, M.D.

Assistant Professor of Clinical Neurology, College of Physicians and Surgeons, Columbia University; Coordinator, Dystonia Clinical Research Center, Columbia-Presbyterian Medical Center, New York, New York

Patients are classified as having movement disorders if they have a disorder of motor programming resulting in either a paucity of movement (akinesia or bradykinesia) or excessive or hyperfunctional movement (hyperkinesia) or a combination thereof. The motor programming error may produce spasms, tremor, jerks or tics, and symptoms related to the body part involved.

For those movement disorders associated with the head and neck, patients are ideally evaluated by an otolaryngologist-head and neck surgeon and by a neurologist specializing in motion disorders. The evaluation should include a complete head and neck examination, neurological examination, videotaping of the functional disability for documentation, and electromyography (EMG), magnetic resonance imaging (MRI), and blood analysis as necessary. In the information that follows, it will be evident that a multidisciplinary approach including an otolaryngologist, a neurologist, and a speech pathologist are key to the successful management of hyperfunctional disorders of the head and neck.

Dystonia

The dystonias make up a large number of the hyperfunctional conditions of the head and neck. Dystonia is a syndrome dominated by sustained

muscle contractions frequently causing twisting and repetitive movements or abnormal postures that may be sustained or intermittent. Dystonia can involve any voluntary muscle. Because the movements and resulting postures are often unusual and the condition is rare, it is one of the most frequently misdiagnosed neurological conditions.[1] The prevalence of the condition is unknown, but we estimate about 50,000 to 100,000 cases of idiopathic dystonia in this country.[2]

As a clinical syndrome, we can classify patients according to clinical symptoms, age at onset, and etiology. Classification may be important since it can give us clues about prognosis and also an approach to management. The classification scheme is outlined in Table 1.

Dystonia may begin at nearly any age. In our experience at the Dystonia Clinical Research Center with more than 2,500 idiopathic cases, we have seen presenting signs as early as 9 months and as late as 85 years (Fig 1). In general, there is a bimodal age at onset distribution with a peak at ages 8 and 42. Therefore, we classify patients as early onset when the present-

TABLE 1.
Classification of Dystonia

Etiology
- A. Primary
  1. Without hereditary pattern
  2. With hereditary pattern
     - Autosomal dominant
     - Autosomal recessive
     - X-linked recessive
     - Undefined
- B. Symptomatic
  1. Associated with other hereditary neurologic disorders (eg, Wilson's disease, Huntington's disease, ceroid lipofuscinosis, progressive supranuclear palsy, Hallervorden-Spatz disease, olivopontocerebellar atrophy, acquired hepatocerebral degeneration, Gilles de la Tourette).
  2. Environmental
     - a. Posttraumatic
     - b. Postinfectious
     - c. Vascular
     - d. Tumor
     - e. Toxic
       - (1). Postantipsychotic drugs (phenothiazines, piperazines, butyrophenones, malindone, thioxanthines)
       - (2). Antiemetics (prochlorperazine, promethazine, metachlopramide)
       - (3). Antiparkinsons drugs (L-DOPA, bromcriptine, lisaride, pergolide)
  3. Dystonia associated with parkinsonism
  4. Hysterical dystonia