I N T R O D U C T I O N

The aetiology of secretory otitis media is still obscure . It has been a general view that the eustachian tube is in some way at fault in this condition (Kersley and Wicham, I966) . It either prevented entry of air into the middle ear, thus causing a vaccum or it failed to facilitate the escape of exudate from the middle ear . The secretory otitis media may be precipitated by allergy or bacterial or viral infection producing inflammatory changes and swelling of the middle ear and eustachian tube mucosa . The inflammatory condition may be perpetuated either by a local allergic reaction or by the irritant nature of the effusion itself .

Secretory otitis media may occur in general diseases e.g. hypogammaglobulinaemia and hypothyroidism (Gibb, I979) .

Hypothyroidism produces profound changes in the ear, nose and throat, Hill (I956), Hollendar (I956) and Ritter (I967). It can produce nasal obstruction due to oedema of nasal mucous membrane, Proetz (I947) , Hilger (I956), Hill (I956) and Ritter (I967), it may play a role in vasomotor rhinitis, Novak (I927) and Semenov (I953), as well as, lymphoid hyperplasia of pharynx, Dalton (I948), all of these changes undoubtedly can affect the eustachian function .

Deafness is a well known symptom in hypothyroidism Ritter and Lowrence (I960), Devos (I963), Ritter (I967) and Meyerhoff (I979) . The reported deafness is mainly sensori-neural,though few reports a conductive hearing loss in hypothyroid patients have appeared in the literature,McMahon (I947),Hill (I948), Laskiewicz (I95I) and Ritter (I967) . The role of hypothyroidism in secretory otitis media, however remains to be elucidated .