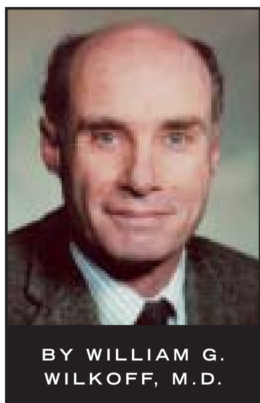
Letters From Maine

Waxing Philosophical



BY WILLIAM G. WILKOFF, M.D.

"My goodness, what is that?"

With the golden brown nugget that was the size of a pencil eraser still perched on my stainless magic wand, I waved it triumphantly and replied, "That, Mrs. Alcott, is a cerumen plug, manufactured by your little Jason and now a trophy we can all be proud of."

"Is that normal?" she replied, still too concerned to bother complimenting me on my skillful extraction. It's happened before. We masters of wax removal have come to expect that our skills are often taken for granted. Fortunately, I have my own sense of satisfaction because for a busy pediatrician there aren't too many bigger highs than removing a big glob of wax in one piece.

Earwax is funny stuff. Most of the time, it's simply providing its owner protection from the elements. Rarely (mostly in teenage boys, it seems), it gets so dense and swollen that it interferes with hearing. More frequently, it serves as an annoying challenge to the assiduous pediatrician who at 4:45 p.m. on a Friday afternoon is trying to determine why an unappreciative 18-month-old has a fever.

When I was in medical school we were offered an hour lecture by someone—a neurologist, I believe—who included among his hobbies the study of earwax and would enlighten us on the topic. Because it was clear that we were never going to be tested on his message, and since it was even clearer that it was a comfortably warm and sunny Thursday afternoon, I opted for some tennis instead.

Had I only known how often my schedule, my emotions, my sense of self-esteem—in effect, my life—would be impacted by cerumen, I think I would have hung around the lecture hall and learned a bit more about my future adversary. But, that's water over the dam.

Once out in practice I learned quickly that if I was going to make good clinical decisions, I needed to see tympanic membranes, and to do this I needed to learn to remove earwax. During my training, no one really showed me how to use an ear curette.

Fortunately, my first partner had a good selection of curettes and I learned which one worked best for me. I learned how deep to go, how to feel with the curette and which way to scrape, how to have a firm hand on the patient and a soft hand on the curette, and certainly how to make sure the child was appropriately restrained. It meant frequent stops to visualize whether I had succeeded, and if not, where I needed to go next.

I learned that if I was unlucky or unskillful and there was some bleeding, that it was best to tell the family that they might see some blood later on, even though it wasn't evident at the moment. Anticipatory guidance saves a mess of evening phone calls.

Even if well done, removing cerumen can be uncomfortable for some patients. Sometimes it can't be avoided. This fact of life and inexperience deters many physicians from doing what is clinically correct and removing enough wax to get a good view of the tympanic membrane.

Every week I see children who were seen in an emergency department or another physician's office, or unfortunately on the floors of tertiary medical centers, whom I know couldn't have had their ears adequately examined. Because when I look in their ears there is a ton of wax, not just a few flakes that may have fallen off the walls of the canal overnight, but a serious amount of impacted wax.

Do I always get enough wax out on the first visit? Of course not, but if the clinical situation demands an adequate exam that day, I don't give up. Luckily there are many situations when I can have the patient return the next day when everyone is more rested.

There is a procedure code for removing cerumen. And if I have done more than scoop out a few flakes, I am not afraid to bill for the work because it appears that I have a skill that is in short supply. ■

DR. WILKOFF practices general pediatrics in a multispecialty group practice in Brunswick, Maine. Write to Dr. Wilkoff at our editorial offices (pdnews@elsevier.com).

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