

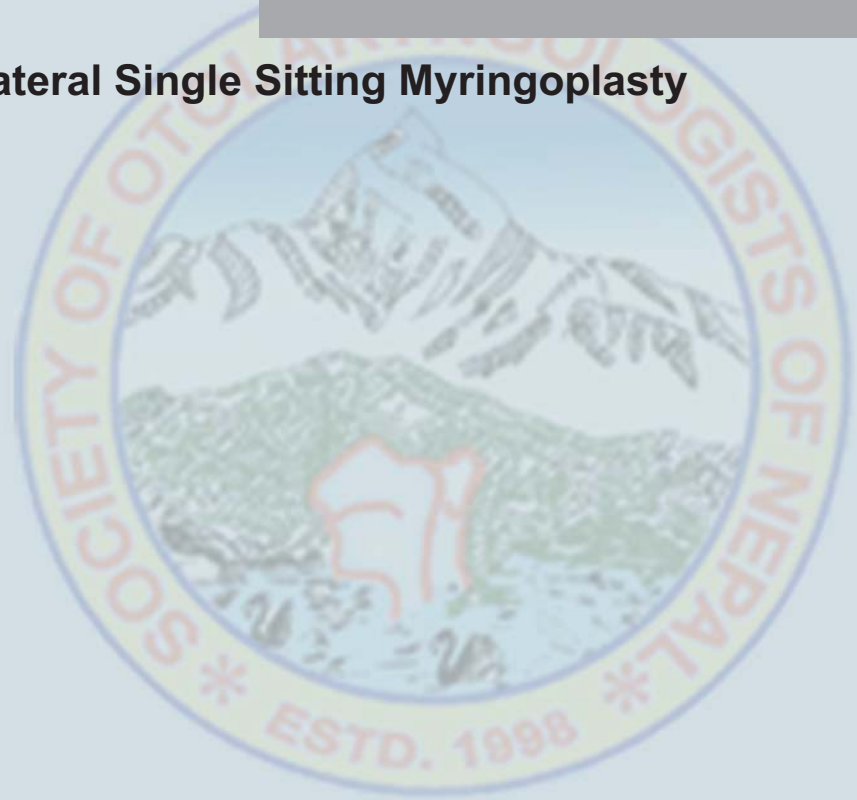
R Guragain

Ganesh Man Singh Memorial Academy of ENT and Head and Neck Studies, TU Teaching Hospital, Kathmandu, Nepal.

Correspondence to

Prof. Rajendra Guragain
Ganesh Man Singh Memorial Academy of ENT and Head and Neck Studies, TU Teaching Hospital, Kathmandu, Nepal.
Email: professorrajendra.guragain@hotmail.com

Bilateral Single Sitting Myringoplasty



Background :

Though there is a theoretical risk of sensorineural hearing loss (1.2 - 4.5 % in the literature), there are many advantages of single sitting bilateral myringoplasty. Single anaesthesia and hospital stay will result into less expenses. It will also reduce the waiting list for surgery. Parents usually prefer single sitting surgery because of above merits also due to less off school of the child. Ours is the first centre who have started bilateral same sitting myringoplasty in children.

Preoperative selection of cases :

Though there is no age bar, older children will fare slightly better after surgery. Ears should be free of infection. Parents are counselled about the surgery and its outcome and consent is taken. Routine blood and urine investigations and pure tone audiogram are obtained. The child is admitted in hospital prior to surgery.

HOW I DO IT:

After orotracheal intubation and positioning of the patient, the ears are examined under the microscope (EUM) and the approach is decided. 2% xylocaine with 1:200,000 adrenaline is injected around incision line and all walls of external auditory canal. Ampicillin 25-50 mg per Kg body weight is injected intravenously. After cleaning the operating site and draping, a generous temporalis fascia graft is harvested from donor side decided by audiometry and EUM findings.

The graft is cut into two halves. One half is placed in sterile myringoplasty set for other ear. Depending on the approach, the wound is closed before or after further procedure (Fig-1, 2 &3). 4-0 vicryl in round body needle is used to apply subcuticular stitches.

Under the microscope, the margin of the perforation is freshened.

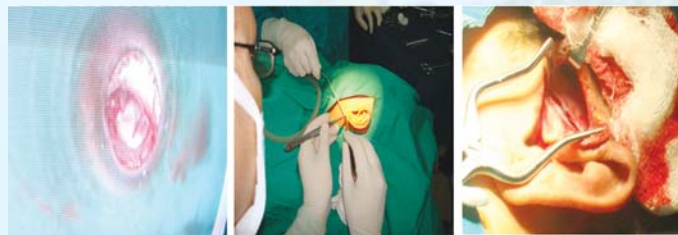


Fig: 1. After graft

Fig: 2. Postaural approach in progress

Fig: 3. Harvesting generous graft

Tympanomeatal flap is raised. Middle ear status is noted (mucosa, ossicular chain and mobility, windows, eustachian tube orifice). Pieces of gelfoam soaked in ciprofloxacin drop are placed in middle ear. Underlay grafting is performed. Flap is repositioned. Ear canal is packed with pieces of gelfoam and BIPP (Bismuth Iodoform Paraffin Paste).

After finishing the procedure in the graft donor side, the surgical team changes gloves and operate the other ear under strict aseptic precautions using new sterile operating set and half of the graft taken initially from the donor ear.

Wound is dressed and mastoid bandage applied covering both ears (Fig-4).

The child is routinely kept on antibiotic (amoxicillin) for 10 days. On the ward the child is nursed with alternate day dressing and analgesics whenever required. The child is sent home after seventh postoperative day. He/she is reviewed after 10 days for removal of ear pack. Then the follow up is on 6th week, 3 months, 6 months and every year. On each visit, complications if any is noted, and pure tone audiogram is performed.

OUTCOME:

We have been routinely doing bilateral single sitting myringoplasty in our department. Results analysed 2 years ago, showed 85% graft uptake. No major complications have occurred so far. The detail outcome is being analysed and will be presented in an international conference and published shortly.



Fig: 4. A happy girl after dressing a wound