**Original Research Article**

**Tympanoplasty with and without mastoidectomy in wet ears: a comparative study**

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**ABSTRACT**

**Background:** Effect of cortical mastoidectomy on graft uptake and graft mobility and thence shift of hearing thresholds was analysed in tympanoplasty in discharging ears.

**Methods:** In this study, 60 subjects of safe chronic suppurative otitis media were selected from the outpatient clinics of Dayanand Medical College and Hospital, Ludhiana. All were subjected to tympanoplasty utilizing the underlay technique. Mastoid exploration was undertaken in the ears with persistent ear discharge.

**Results:** Cortical mastoidectomy performed in 20 (33.3%) out of 60 patients and most of cases were done in superiorly based/superior cuff tympanoplasty group in our study. No statistically significance found between cortical mastoidectomy and different flap technique. Mean hearing gain is more with cortical mastoidectomy (16.85 dB) than without cortical mastoidectomy (13.05 dB) and graft uptake was 97.5% without cortical and 95% with cortical mastoidectomy.

**Conclusions:** There was higher mean gain in thresholds of hearing in subjects with cortical mastoidectomy with tympanoplasty though uptake was almost equal to those without mastoidectomy.

**Keywords:** Cortical mastoidectomy, Graft uptake, Hearing gain, Wet ear

**INTRODUCTION**

The surgical repair of tympanic membrane perforation was first described by Berthold 1878 as Myringoplasty.¹

The earliest attempt to re-establish a connection between the tympanic membrane and the oval window in the case of a missing ossicle was in 1901. Battista et al, Louis Petit 1700s first described the procedure cortical mastoidectomy but it didn’t gain acceptance until 1958, and was later popularized by William House.²,³

Myringoplasty is the surgical reconstruction of the tympanic membrane. Tympanoplasty is the surgical reconstruction of the tympanic membrane. Cortical mastoidectomy is a procedure to remove mastoid air cells without affecting the middle ear and typically done for mastoiditis.

Cortical mastoidectomy has been justified in cases of CSOM, refractory to antibiotic therapy and for the eradication of disease process. On the contrary some propagate that mastoidectomy is unnecessary and increases patient risk with no significant advantage in clinical outcome- Jackler et al.⁴

The primary role of mastoidectomy is in the improvement of middle ear and mastoid- Milieu intérieur in terms of ventilation and drainage of the temporal bone/mastoid air cell system (MACS).
Aerated mastoid acts as a buffering system to reduce the impact of pressure changes experienced by the middle ear by Holmquist et al, Sade et al and Richards et al.  

Overall success rate of tympanoplasty, with or without mastoidectomy, in the treatment of chronic pediatric otitis media, was high and did not depend on patient age, the status of the contralateral ear, the inclusion or absence of surgical mastoidectomy, or the method of mastoidectomy Yoon et al 2007.

Aim of the study was to compare results of tympanoplasty with and without cortical mastoidectomy in discharging ears.

**METHODS**

60 cases of safe chronic suppurative otitis media were selected from the otology clinics of Dayanand Medical College and Hospital, Ludhiana. The study was conducted for the period of 1 year from June 2015 to August 2016.

All the patients fulfilled the standard criteria for tympanoplasty a proper work out was carried out as per the performa.

**Inclusion criteria**

Patients with tubotympanic/mucosal safe perforations.

**Exclusion criteria**

Patients with aticoantral/squamosal unsafe perforations; otitis externa; ossicular discont inuity.

Patients with both dry and wet ears were taken and different flap techniques were used randomly. Clinical and hearing assessment was carried out at 2 weeks, 4 weeks, 3 months and 6 months in all the patients. The graft uptake, graft mobility with valsava and pneumatic seigalisation, and the hearing gain in patients with cortical or without cortical mastoidectomy was also compared.

**Statistical analysis**

All statistical calculations were done using Statistical Package of Social Sciences (SPSS) 17 Version statistical program for Microsoft windows (SPSS Inc. released 2008. SPSS statistic for windows, version 17.0, Chicago). Ethical approval of the study was taken from the Institutional Ethics Committee.

**RESULTS**

**Demographic profile**

Maximum numbers of patients were in the age group of 31-40 years (26.7%), followed by age group of >50 years (23.3%). 11 years was noted to be the minimum age whereas the maximum was noted to be 65. Mean age was 36.67.
Cortical mastoidectomy had to be performed in 20 (33.3%) patients in our study of 60 patients.

Cortical mastoidectomy performed in 20 (33.3%) out of 60 patients and most of cases were done in superiorly based/superior cuff tympanoplasty group in our study. No statistically significance found between cortical mastoidectomy and different flap technique.

McGrew et al compared the surgical outcome of repair of tympanic perforation with and without canal wall up mastoidectomy.\textsuperscript{10} Tympanic membrane repair was equally effective in both groups and the hearing results were comparable. They proposed the futility of cortical mastoidectomy for successful repair of simple tympanic membrane perforations.

A graft take-up rate of 91.6% and 90.6% was recorded in patients who had tympanoplasties with and without cortical mastoidectomy, respectively by McGrew et al.\textsuperscript{10}

In present study cortical mastoidectomy was performed in 20 out of 60 patients and found that graft uptake was equal in patient with or without cortical mastoidectomy but the mean hearing gain was more in patients with cortical mastoidectomy (16.85 dB) than without cortical mastoidectomy (13.05 dB).

CONCLUSION

There was higher mean gain in thresholds of hearing in subjects with cortical mastoidectomy with tympanoplasty though uptake was almost equal to those without mastoidectomy.

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