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Letter to the Editor

Grommet insertion based on flat tympanogram! Is the practice defendable?

Dear Sir,

I am interested in the Audit article by Ryan *et al.*[1] on the management of paediatric otitis media with effusion in the UK, a survey conducted with the guidance of the Clinical Effectiveness Unit at the Royal College of Surgeons of England. Amongst the consultant otolaryngologists responding to the survey, the majority of them did not have access to distraction test (50 per cent) or VRA (60 per cent). It is therefore assumed that these consultants mostly depend on tympanometry for the decision to operate in young children. OME can co-exist with sensorineural hearing loss.[2] Grommet insertion in these young children, without age appropriate audiological threshold before and after surgery, can be misleading giving the parents and professionals a false sense of assurance. A significant disability can be missed and more importantly valuable time is lost in initiating the appropriate management if threshold information is not available both prior to and after surgery. A recent publication by the MRC has shown that the degree of hearing loss due to glue ear at presentation is an important indicator of persistence of bilateral OME.[3] The appropriate management strategy of glue ear can therefore depend on the threshold information. There are also young children frequently seen in the Paediatric Audiology Clinics who have flat tympanograms but normal hearing thresholds.

Grommet insertion based on flat traces therefore means that some children with sensorineural hearing losses will be missed or unnecessary surgery will be carried out in a number of young children with normal hearing. If the value of pure-tone audiogram in older children before grommet insertion is not debateable why should there be a debate in arranging distraction test or VRA in younger children? I feel that distraction test and VRA are essential in the appropriate age groups both before and soon after grommet insertions in order to provide a holistic child-centred audiological care rather than just treating the tympanogram.

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References

1 Ryan R, Harkness P, Fowler S, Topham J. Management of paediatric otitis media with effusion in the UK: a survey conducted with the guidance of the Clinical Effectiveness Unit at the Royal College of Surgeons of England. *J Laryngol Otol* 2001;**115**:475–9

2 Vartianen E. Otitis media with effusion in children with congenital or early onset hearing impairment. *J Otolaryngol* 2001;**29**:221–3

3 MRC Multicentre Otitis Media Study Group. Risk factors for persistence of bilateral otitis media with effusion. *Clin Otolaryngol* 2001;**26**:147–56