



Outcome of Interlay Type 1 Tympanoplasty for Large Central Perforation

Mahmudul H*

Department of otolaryngology and Head-Neck surgery, Khulna medical College, Bangladesh

*Corresponding author: Mahmudul Huq, Department of otolaryngology and Head-Neck surgery, Khulna medical College, Bangladesh, Email: mahmudent72@gmail.com

Received Date: December 17, 2020; Published Date: December 30, 2020

Abstract

Background: Perforation of the tympanic membrane may occur from various reasons. Most of these perforations heal spontaneously, whereas the remaining long-standing perforations that lead to recurrent ear discharge need 1tympanoplasty. Interlay Type 1Tympanoplasty, a newer technique has shown promising results with higher success rate in terms of hearing gain and graft uptake.

Objective: To analyze the results of interlay Type 1Tympanoplasty in terms of graft uptake and hearing improvement in cases of inactive mucosal chronic otitis media [COM] with large central perforation.

Material and Methods: This is a prospective study of 24 months (January 2018 to December2019) duration conducted in department of E.N.T, Khulna medical college, Khulna and data was collected from the 60 patients admitted for Myringoplasty. Results were calculated in terms of graft accepted or rejected and decrease in air bone gap.

Result: The graft uptake rate in the present study was found to be 91.67% and the patients reported an improvement in terms of hearing. Pre operatively mean air bone gap was 26.5 dB and Post operatively after 12 weeks mean air bone gap improved to 17.58 db.

Conclusion: Interlay Type 1Tympanoplasty is an effective technique over conventional methods in terms of both graft uptake as well as hearing improvement in large central perforation

Keywords: Chronic Otitis Media; Interlay; Type 1 Tympanoplasty; Graft uptake

Introduction

Chronic otitis media (COM) is a major health problem in a developing country like Bangladesh, especially in low socio economic strata (prevalence > 10%). COM has a major impact on the social life of a person in the form of hearing disability [1]. The discharge from the ear is also troublesome causing great discomfort to the patient.

Perforation of the tympanic membrane primarily results from middle ear infections, trauma or iatrogenic causes. Up to 80% of these perforations heal spontaneously [2]. For the remaining, surgical repair, known as 1tympanoplasty, is usually proposed. 1Tympanoplasty is a procedure done to repair the defect in the tympanic membrane after eradicating all the disease in the middle ear cleft with or without reconstruction of ossicular chain [3]. Type 1 tympanoplasty is a surgical technique that involves the repair of the

tympanic membrane in cases where the only existing lesion is a tympanic membrane perforation. It is the most common otological procedure after myringotomy [4].

Tympanoplasty is one of the most commonly done otological procedures. It was introduced by Berthold and further developed by Wullstein and Zollner [5-7].

Many techniques of myringoplasty are described in the literature. A few of the numerous techniques include Underlay [8] Overlay [9], Inlay [10], Interlay [11].

It is classified based on the placement of graft in relation to the remnant tympanic membrane as:

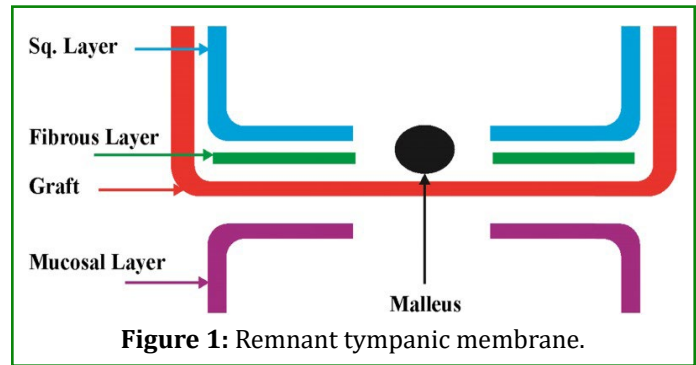
- Underlay technique-graft is placed medial to the mucosal layer.
- Overlay technique-graft is placed lateral to the fibrous layer of tympanic membrane after elevating all squamous epithelium.
- Interlay technique-graft is placed between fibrous and the endothelial (mucosal) layer of the drum remnant [12].

Each technique has its advantage as well as disadvantage. Some of the workers are of the view that overlay technique is more useful in repairing large and anterior perforation while Underlay technique is ideal for posterior perforation [13].

Underlay technique is considered technically easier, less time-consuming and has shown to be having higher success rate [14].

Interlay technique has many advantages upon the underlay and overlay technique. In it the graft is kept in between the mucosal and the fibrous layers which eventually grow on the inner and the outer surface of the graft leading to closure of the perforation. Thus this mucosal and fibrous layer plane is the most physiological plane for keeping the graft layer thus contributing to the following advantages:

- There is no blunting, as the anterior sulcus is skin lined.
- No lateralization, as the graft is placed medial to malleus and fibro-squamous layer.
- No epithelial cyst formation.
- No medicalization.
- Can clear tympanosclerosis from anterosuperior quadrant easily.
- Myringitis due to endothelium overgrowth on the graft is avoided.
- No reduction in middle ear space.
- The Interlay approach has shown promising results with success rates higher than 90% [15-19].



Aims and Objectives

- To evaluate the results of type 1 tympanoplasty by interlay technique
- To assess the uptake of graft
- To assess the hearing improvement
- To study complications associated with interlay technique

Methods

Study design and setting

The present study is a randomized prospective study of 24 month duration from January 2018 to December 2019 in 60 patients of chronic otitis media inactive mucosal type with large central perforation admitted in the E.N.T department at Khulna Medical College and Hospital, Khulna. The study was conducted after getting ethical clearance from the Ethical committee. Patients and the attendants were informed and counseled regarding the disease process, surgical procedure involved and the expected outcomes, complications and alternative treatments available. Written and informed consent was taken from the patient as well as the attendant.

Study period: The duration of study was two year from January 2018 to December 2019. The follow up period was 3 months.

Sample size: 60 patients from the outpatient department of E.N.T at the Khulna Medical College and Hospital, Khulna. Results were calculated in terms of graft take up rate and hearing improvement.

Inclusion criteria: Cases of chronic otitis media with inactive mucosal disease with a large central perforation and pure conductive hearing loss were included in the study. The ear was dry for at least 6 weeks. Both males and females in the age group of 15 to 60 years of age were included in the study.

Exclusion criteria: Following patients were excluded from the study- Patients with active mucosal disease; patients with squamosal disease; patients with acicular discontinuity/necrosis; patients with sensor neural and mixed hearing loss;

patients below 15 years and above 60 years were excluded from the study; patients with diabetes mellitus; patients with active focus of infection in throat, nose and oral cavity; patients with recurrent disease (revision cases); patients who fail to follow-up for at least 3 months.

Procedure All cases of Chronic Otitis Media with large central perforation and conductive hearing loss (After diagnosing by Pure Tone Audiometry and Otomicroscopy were admitted in the E.N.T. ward, relevant history, clinical findings, tuning fork tests, routine investigations along with X-Ray mastoid and Diagnostic Nasal Endoscopy (DNE) were carried out. Pre-operatively all patients had a Pure Tone Audiogram with an average of four frequency (0.5/1/2/4 KHz) calculated for both air conduction and bone conduction. Post auricular approach and temporalis fascia was used as a graft material in techniques of Myringoplasty under local Anesthesia.

Results

The present study comprised of total 60 patients of which 27(45%) were male and 33(55%) were female patients. The age of the patients ranged from 17 to 60 years, with the mean age group 32.53 years with standard deviation 9.37. Maximum numbers of patients were in the age group of 21 to 30 years.

Age group (years)	Number of patients	Percentage (%)
17- 20	6	10
21- 30	24	40
31- 40	20	33.33
41-50	8	13.33
51-60	2	3.33
Total	60	100

Table 1: Age distribution of the patients.

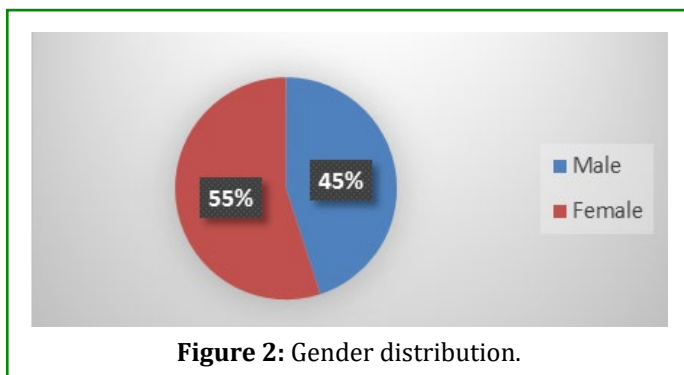


Figure 2: Gender distribution.

The preoperative air-bone gap (ABG) was between 11 and 20 dB in 10(16.67%) patients, 21 and 30 dB in 35(58.33%)

patients and 31–40 dB in 15(25%) patients, with the mean ABG being 26.5 dB with standard deviation of 6.98 as shown in table 2.

Preoperative ABG(dB)	Number of patients	Percentage (%)
<10	0	0
20-Nov	10	16.67
21-30	35	58.33
31- 40	15	25

Table 2: Preoperative air bone gap of the patients.

Post operatively graft accepted in 55(91.67%) patients while graft rejection was observed in 5(8.33%) patients at the end of 12 weeks as shown.

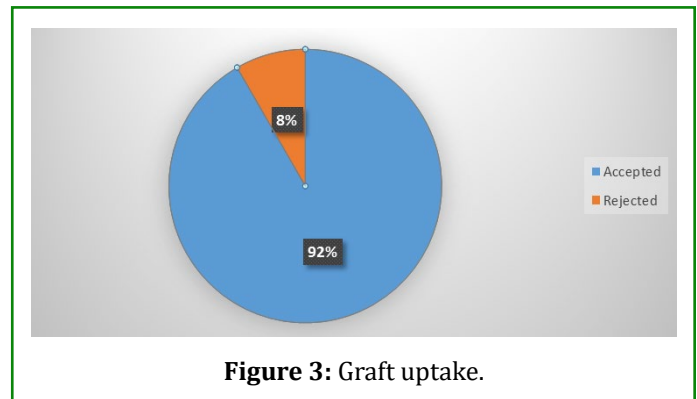


Figure 3: Graft uptake.

At the end of 12 weeks the postoperative mean ABG was reduced to 17.58 dB with standard deviation 6.88 and the postoperative ABG changing to less than 10 dB in 8(13.33) patients, between 11 and 20 dB in 38(63.33) patients and between 21 and 30dB in 11(18.33%) patients and no improvement in 3(5%) patients, all of which were statistically significant.

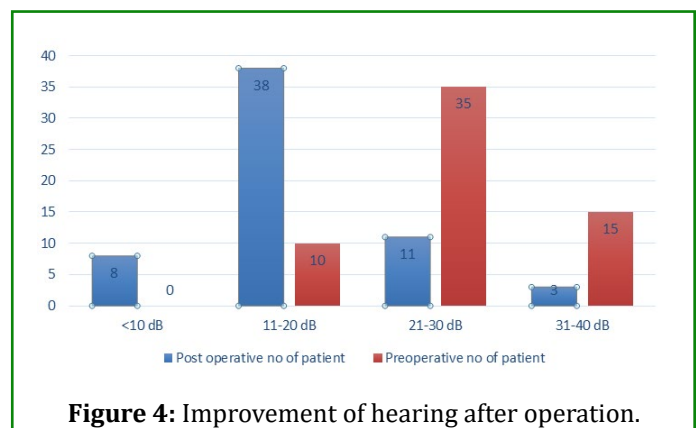


Figure 4: Improvement of hearing after operation.

ABG(dB)	Number of patients Post-operative	%
<10	8	13.33
20-Nov	38	63.33
20-30	11	18.33
31-40	3	5

Table 3: Postoperative air bone gap of the patients.

Complications	Number of patients	Percentage (%)
Graft medialization	0	
Graft lateralization	0	
Perforation	5	8.33
Post aural wound infection	1	1.66
Granular myringitis	0	
Alteration of test	0	
Total	7	11.66

Table 4: Complications.

Discussion

Bangladesh is one of the countries with highest load of chronic otitis media [19]. It is important being a curable cause of deafness. It is mostly the end result of acute otitis media and is characterized by deafness and persistent discharge from the middle ear through a tympanic membrane perforation.

Tympanoplasty is the operative procedure performed to close the perforation in ear drum by repairing the tympanic membrane [6]. It is a beneficial procedure to protect the middle ear and inner ear from future damage. Improvement in hearing sensitivity is also observed [20].

Tympanoplasty has come a long way after it was first introduced by Wullstein and Zollner in the early 1950s [21] as there was a constant desire to improve the technique as well as outcomes. In the past few years, interlay technique of tympanoplasty has gained a lot of popularity and has emerged as the preferred approach because of its low incidence of complications and promising results.

In the present study, the graft uptake rate was found to be 91.67% which is in accordance with study by Kawarau, et al. [22] who reported success rate of 93.3% and is slightly better than study conducted by Hay et al [23] on 116 ears who found success rate of 91%.

Jain S, et al. [24] studied 500 cases and reported the success rate of 96.6 and Patil, et al [12] reported 96% which is

slightly better than our results. Komune S, et al. [11] studied interlay myringoplasty in 69 ears and achieved success rate of 94.2%, in the present study mean ABG changed from 26.5 dB preoperatively to 17.58 dB post operatively at the end of 12 weeks.

In study by Subramanian, et al. [25] mean ABG changed from 28.5 dB preoperatively to 15.83 dB post operatively. In study by Jain S, et al. [24] the mean ABG was 26.08 ± 8.32 dB and mean postoperative ABG reducing to 10.12 ± 5.84 db. In the study by Kawatra, et al. [22] ABG improved from 27.50 dB preoperatively to 13.67 dB postoperatively after 16 weeks and in study by Patil, et al. [12] the mean preoperative ABG was 36.42 ± 12.01 dB which improved to 9.7 ± 6.71 dB at the end of 3rd month.

In the present study Only 5 (8.33%) patients had graft failure. There was no improvement in hearing in 3(5%) patients. Complication Occur in 7(11.66%) patients which is consistent with the study by Patil, et al. [12].

Conclusion

Although Interlay myringoplasty technique requires additional expertise in surgery, it is an effective technique over conventional methods like overlay or underlay for graft uptake and hearing gain in large central perforation .The complications associated with this are less as compared to other techniques. This study indicate interlay is the best approach for chronic otitis media with large central perforation of mucosal variety.

References

1. Matsuda Y, Kurita T, Ueda Y, Ito S, Nakashima T (2009) Effect of tympanic membrane perforation on middle-ear sound transmission. *J Laryngol Otol* 123(31): 81-89.
2. Galdstone HB, Jackler RK, Varav K (1995) Tympanic Membrane Wound Healing. An Overview. *Otolaryngol Clin North Am* 28(5): 913-932.
3. Castro-Sismanis A (2010) Tympanoplasty: tympanic membrane repair. *Glasscock-Shambaugh Surgery of the ear*. 6th (Edn.), Peoples Medical Publishing House, Shelton, pp: 465-488.
4. Castro O, Pérez-Carro AM, Ibarra I, Hamdan M, Meléndez JM, et al. (2013) Myringoplasties in children: our results. *Acta Otorrinolaringologica* 64(2): 87-91.
5. Berthold E (1878) Overlay myringoplasty. *Weir Med Bull* 1: 627.
6. Wullstein H (1956) Theory and practice of tympanoplasty.

Laryngoscope 66(8): 1076-1093.

7. Zollner F (1955) The principles of plastic surgery of the sound-conducting apparatus. *J Laryngol Otol* 69(10): 637-652.
8. Shea JJ Jr (1960) Vein graft closure of eardrum perforation. *J Laryngol Otol* 74: 358-362.
9. House WF (1960) Myringoplasty. *Arch Otolaryngol* 71: 399-404.
10. Eavey RD (1998) Inlay tympanoplasty: cartilage butterfly technique. *Laryngoscope* 108(5): 657-661.
11. Komune S, Wakizono S, Hisashi K, Uemura T (1992) Interlay method for myringoplasty. *Auris Nasus Larynx* 19(1): 17-22.
12. Patil BC, Misale PR, Mane RS, Mohite AA (2014) Outcome of interlay grafting in type 1 tympanoplasty for large central perforation. *Indian Journal of Otolaryngology and Head & Neck Surgery* 66(4): 418-424.
13. Kartush JM, Michaelides EM, Becvarovski Z, LaRouere MJ (2002) Over-under tympanoplasty. *The Laryngoscope* 112(5): 802-807.
14. Singh M, Rai A, Bandyopadhyay S, Gupta SC (2003) Comparative study of the underlay and overlay techniques of myringoplasty in large and subtotal perforations of the tympanic membrane. *The Journal of Laryngology Otology* 117(6): 444-448.
15. Komune S, Wakizono S, Hisashi K, Uemura T (1992) Interlay method for myringoplasty. *Auris Nasus Larynx* 19(1): 17-22.
16. Guo M, Huang Y, Wang J (1999) Report of myringoplasty with interlay method in 53 ears perforation of tympani. *Lin chuang er bi yan hou ke za zhi* 13(4): 147-149.
17. Vishal US (2004) A one-year prospective study to evaluate the results of superiorly based tympanomeatal flap in endoscopic myringoplasty conducted in district hospital, belgaum and kles hospital and mrc, belgaum.
18. Hay A, Blanshard J (2014) The anterior interlay myringoplasty: outcome and hearing results in anterior and subtotal tympanic membrane perforations. *Otology & Neurotology* 35(9): 1569-1576.
19. World Health Organization (2004) Chronic Supportive Otitis Media: Burden of illness and management options, Geneva.
20. Hussain A, Yousaf N, Khan AR (2004) Outcome of Myringoplasty. *J Postgrad Med Inst* 18: 693-696.
21. Primrose WJ, Kerr AG (1986) The anterior marginal perforation. *Clin Otolaryngol Allied Sci* 11(3): 175-176.
22. Kawatra R, Maheshwari P, Kumar G (2014) A comparative study of the techniques of myringoplasty -Overlay, underlay & interlay. *IOSR J Dent Med Sci* 13: 12-16.
23. Hay A, Blanshard J (2014) The anterior interlay myringoplasty: Outcome and hearing results in anterior and subtotal tympanic membrane perforations. *Otol Neurotol* 35(9): 1569-1576.
24. Jain S, Gupta N, Gupta R, Roy A (2017) Interlay Type I tympanoplasty in large central perforations: Analysis of 500 cases. *Indian J Otol* 23(1): 32-35.
25. Subramanya BT, Lohith S, Sphoorthi B (2018) Interlay myringoplasty: hearing gain and outcome in large central tympanic membrane perforation. *Tropical journal of ophthalmology and otolaryngology* 3(3): 51-56.