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Editorial *Volume 5 Issue 1*

Intraoperative Complications of Stapes Surgery

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Editorial

If otosclerosis surgery is classically described as a series of perfectly coordinated steps, each stage can be marked by variations (often related to the patient's anatomy) or complications that disrupt the course of the procedure. These intraoperative variations and incidents most often occur unexpectedly, and the surgeon must be familiar with them to know how to handle them.

Tympanic membrane tear may occur in case of unfavorable anatomy, a thin atrophic tympanic membrane or inattention to tympanomeatal flap elevation [1,2]. When the latter is returned to its natural location, simple injury can be reapproximated by advancing the flap. A large defect in the tympanic membrane should be repaired [1,2]. In order to have adequate exposure of the oval window, the chorda tympani nerve may be stretched or cut [1]. This may result in temporary taste disorder [2]. Associated fixation of the malleus or incus should be suspected during middle ear exploration: mobility of all ossicles must be individually tested [1]. An unidentified ossicular fixation could be the cause of the postoperative failure to close the air bone gap [1].

The incus may be dislocated. The first step is to return the incus to its natural position, relying on healing of the ligaments to retain it [1]. However, if the dislocation is severe, a malleostapedotomy is indicated. The long process may be fractured (due to its occasional pneumatization). In this case, a malleostapedotomy should be performed [1].

The most known complication when performing fenestration of the ankylosed footplate, is the floating footplate. The latter should be removed. If a depression of the footplate into the vestibule occurs, the depressed footplate should be left in the vestibule, and a shorter-than-required prosthesis should be inserted in the oval window after placing a tissue graft [1,2]. Placement of a control hole and the use of laser may prevent this complication and help to manage it [2]. Another rare event that can occur during stapedotomy is a perilymphatic gusher. Patience and composure are necessary for gusher management. A tissue graft can be positioned over the stapedotomy and prosthesis can be positioned normally once the flow of cerebrospinal fluid has stopped [2].

The facial nerve may be injured if it is prolapsed or dehiscent [2]. The procedure should be stopped when a prolapsed facial nerve completely obscures a view of the footplate [1]. Persistent stapedial artery may be cauterized or be circumvented by insertion of a piston prosthesis adjacent to the vessel [1].

References

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