The Journal of Laryngology & Otology (2006), ***120***, *226–227.*

doi:10.1017/S0022215106000144
Printed in the United Kingdom

Short Communication

Grommet insertion: a novel technique

R K Sharma, FRCS(ORL-HNS), N Bateman, FRCS(ORL-HNS), P D Bull, FRCS

Abstract
We describe a new technique for inserting grommets which is both easy to master and provides better visualization of the tympanic membrane. This is particularly helpful in patients with narrow ear canals.

Key words: Otitis Media with Effusion; Middle Ear Ventilation; Surgical Procedures, Operative

Introduction

Myringotomy with grommet insertion is commonly performed in the UK for persistent otitis media with effusion and/or recurrent acute otitis media. An estimated 70 000 operations are carried out in Britain per anum.[1]

It has been conventional teaching to grasp the grommet at either its upper or lower edge (Figure 1a) with fine crocodile forceps prior to insertion. Care should be taken not to insert the jaw into the lumen of the ventilation tube as this makes inserting the flange under the superior margin of the incision more difficult.[2] A disposable grommet introducer is available in which a retractable stylet inserted into the lumen of the grommet is used, but the orientation of this makes the procedure difficult when inserting a Shah grommet.

We describe a new method of holding the grommet, which has been developed and practised by the senior author. To the best of our knowledge, this has not been described elsewhere in the literature.

Technique

A myringotomy incision is made in the antero-inferior quadrant of the tympanic membrane unless there is a reason for not doing so. The grommet is positioned using a 'non-touch' technique and picked up from its pack using fine crocodile forceps. It is held at its waist with the jaws of the forceps at the sides of the grommet and the hand grip turned to the right (for a right-handed surgeon) (see Figure 1b). The grommet is inserted into the ear canal such that the shaft of the forceps is parallel to the flange (Figure 2), which can be easily slid under the anterior edge of the incision and, if necessary, assisted into position by a needle or a suction tip.

We have found this technique particularly suitable for the Shah design of ventilation tube.

Discussion

Learning to insert a grommet can be a challenge to the trainee surgeon.

We feel the above technique is substantially easier to practise and master. It has been widely adopted by the surgeons in our department. Gripping at the waist provides a firmer grasp and makes visualizing the incision and inserting the ventilation tube a lot easier, with less potential trauma to the ear canal.

This technique of holding the grommet with the forceps also simplifies the mounting of the grommet for scrub nurses, when they are called upon to do this. In patients with narrow external auditory canals, we feel that visualization of the tympanic membrane is also improved.

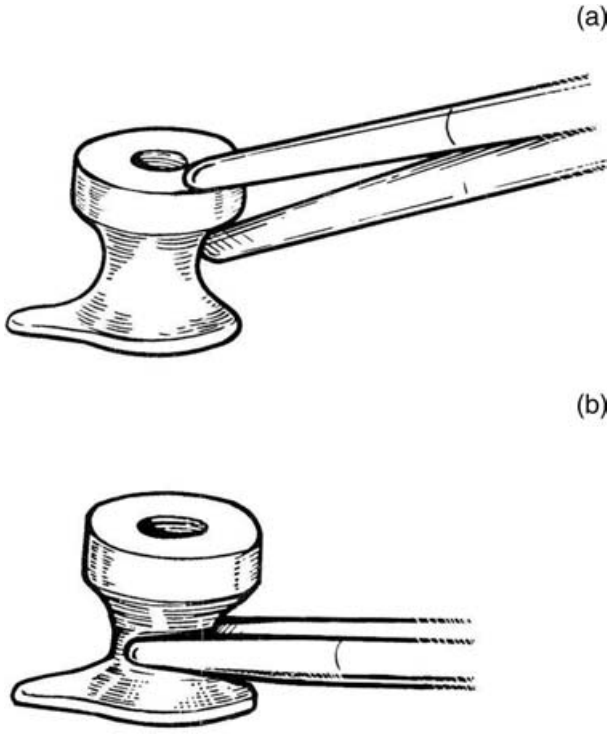

Fig. 1
(a) The Shah grommet is held in the conventional manner, at its upper edge. (b) The grommet held at its waist, as proposed by the new technique.

From the Department of ENT, Head and Neck, Sheffield Children's Hospital, Sheffield, UK.
Accepted for publication: 14 September 2005.

FIG. 2
Insertion of grommet in the tympanic membrane.

References

1 Odutoye T, McGilligan A, Robb PJ. Aseptic surgical technique and post grommet otorrhoea. *Int J Pediatr Otorhinolaryngol* 2003:**67**(suppl 1):S233–5
2 Ransome J. *Rob and Smith's Operative Surgery – Ear*, 4th edn. London: Butterworths, 1986;31–2

Address for correspondence:
Mr R K Sharma,
64, Daisy Hall Drive,
Westhoughton,
Bolton BL5 2SB, UK.

E-mail: ravibha@hotmail.com

Mr R K Sharma takes responsibility for the integrity of the content of the paper.
Competing interests: None declared