Clinical Records

Grommets—A Simple Technique for their Manufacture

By John K. Duff (Barbados)

The practice of placing grommets in the tympanic membrane is growing. From the routine treatment of serous otitis, indications have spread to include Ménière's disease, possibly post stapedectomy air travel and as it affects this air-served island prophylactic insertion following an episode of barotrauma on arrival, ensuring comfort and obviating further damage on the return flight.

I have found the following technique simple, rapid and inexpensive.

The required apparatus includes:

Polythene tubing, O.D. 1 mm.; One hypodermic needle 25G. with the point broken off; One No. 11 scalpel blade; One pair of scissors or wire nippers; Stainless steel wire—as for a Schuknecht stapes prosthesis; One spirit lamp.

Technique: 4 mm. of tubing are cut off and threaded on to the hypodermic needle so that the needle tip is fractionally clear of the tubing. (1. Fig. 1). The needle is very slowly advanced towards the flame of a spirit lamp (avoid draughts). The presenting edge of the polythene, as the heat increases, rolls

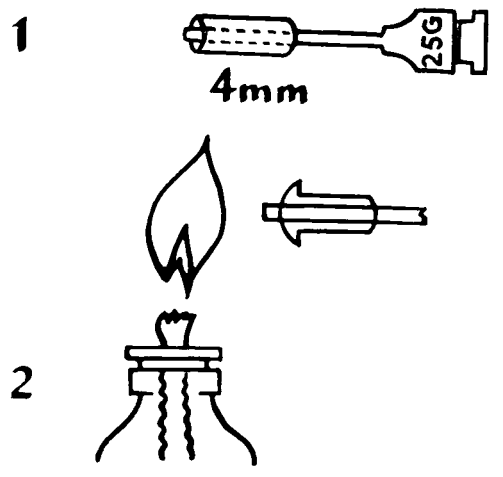


Fig. 1.

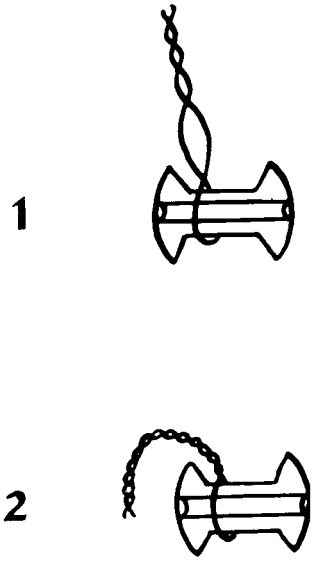


Fig. 2.

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back in a regular and highly satisfactory way, away from the flame, along the needle (2. Fig. 1). This should take up about 1 mm. of the tube. Remove the tube, turn it round and deal similarly with the other end. This whole procedure requires a little practice to ensure a grommet of professional appearance. Slip the formed grommet off the needle and hold it up to the light to ensure patency and regularity of lumen.

The wire is next tied on to the grommet at one end with a simple single knot (1. Fig. 2). After drawing the knot firmly (it is possible to occlude the lumen)—the wire is twisted from the grommet to a distance of about 1 cm. This can be done in the fingers, or by holding the wire in artery forceps. When the twist is tight and regular, it is cut about 5 mm. from the end of the grommet and bent in a U, so that the free end lies about 2 mm. in front of the grommet (2. Fig. 2). This manœuvre enables the surgeon to grasp the wire for insertion and the grommet will lie in a direct line with the inserting forceps.

It is then a matter of the greatest simplicity to pass the grommet through the myringotomy incision—the grasp of the forceps coming cleanly and easily off the wire.

The shortness of the wire keeps the grommet safe from exploring fingers, and is easily grasped for removal.

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