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A simple method for preparing an ear wick

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Abstract
We present a simple method for preparing an ear wick for treating otitis externa in ENT outpatient clinics. In our experience, this method is efficient, economical and clean, and ensures an equal distribution of the medication along the wick.

Key words: Ear Wick; Otitis Externa

Introduction

Otitis externa is an extremely common disease encountered in busy ENT outpatient clinics. After performing aural toilet, insertion of an ear wick is a common practice for many surgeons, since it allows continuous release of medication as well as absorption of any excess secretions. We present a simple, cost-effective method.

Methods

The procedure requires a piece of ribbon gauze of appropriate size, two clean (preferably sealed) wooden tongue depressors, aural Tilleys forceps and antibiotic/steroid cream (Figure 1). The ribbon gauze is placed on one tongue depressor and a small amount of the cream is instilled onto it. With the use of the other tongue depressor, the cream is spread on the gauze from the proximal to the distal end (Figures 2 and 3). To prevent displacement of the gauze during movement, the proximal tip of it can be stabilized with the thumb and finger of the hand holding the tongue depressor. This movement can be repeated several times in several directions (in a spreading fashion) to ensure a complete spread of the cream over all parts of the gauze. Some added pressure whilst spreading would ensure the cream reaches the other side of the gauze facing the tongue depressor. Any excess cream on the edges of the tongue depressor, resulting from the pressure applied, can be recollected and placed again on the gauze, making maximum use of the cream (Figure 4). The end result is a smooth, intact, well-prepared wick (Figure 5).

Discussion

Preparing an ear wick can be time-consuming and troublesome, and in addition a significant amount of cream can be wasted as the surgeon attempts to ensure an equal distribution of the cream along the wick. It was noticed in our previous practice that attempts to unfold or squeeze the wick after mixing with the cream lead to contamination (as one may be tempted to touch it with hands), fragmentation and tearing of fibres. Also, more tools were needed (Gallipot, gloves and more than one instrument to hold the gauze). We also observed that excess amounts of cream in the external ear canal during wick insertion can obstruct the view, leading to loss of direction and possible misplacement of the wick.

After we introduced this new method into our department, we observed that the process was both quick and efficient, as the amount of cream consumed was markedly reduced. There was also less dependence on nurses' assistance. Although the technique was not considered sterile this was not of serious concern, as wick insertion is usually performed with unsterile instruments commonly available in the ENT clinic.

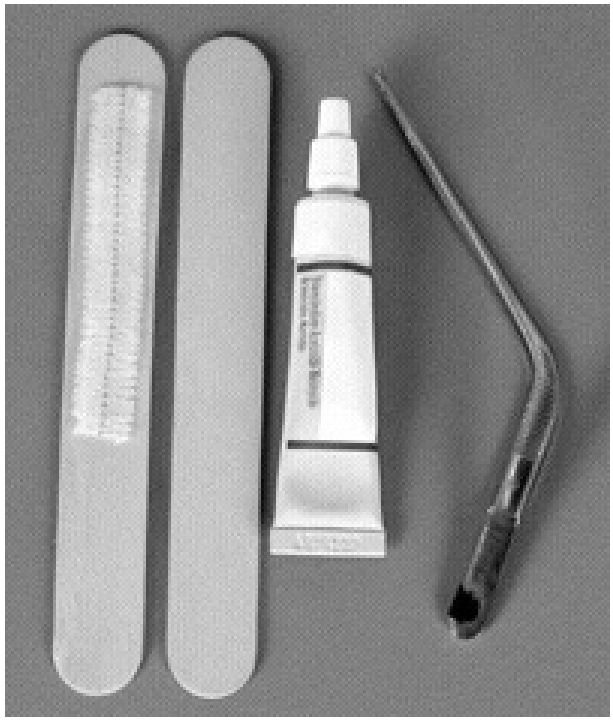


FIG. 1

Equipment required: two wooden tongue depressors, aural Tilleys forceps, a dry piece of ribbon gauze and antibiotic/steroid cream.

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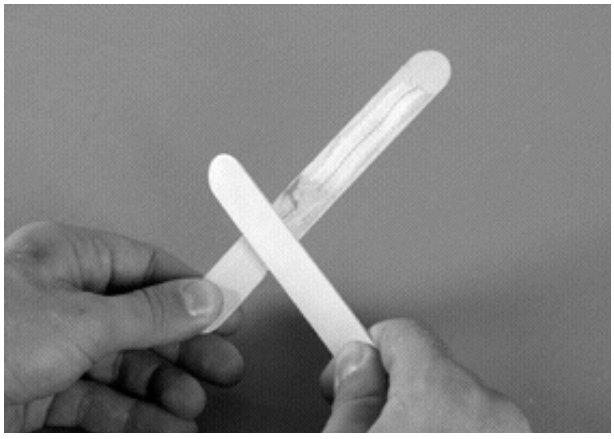


FIG. 2
The piece of ribbon gauze is placed on one tongue depressor and a minimal amount of cream is instilled over it.

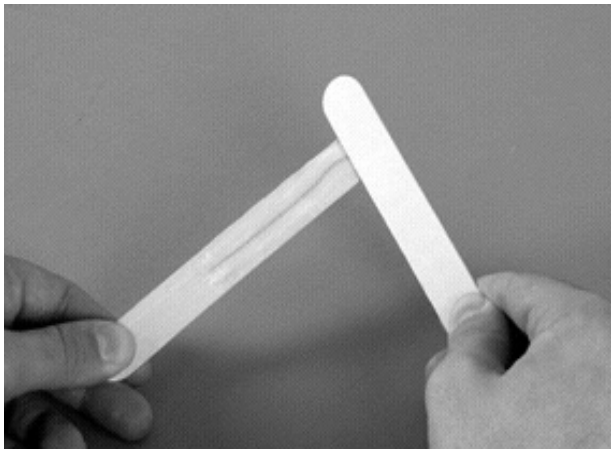


FIG. 3
Cream spreading starts from the proximal to the distal end using the other tongue depressor. Spreading can then be in any direction, similar to the spreading of a 'tympanoplasty graft'.

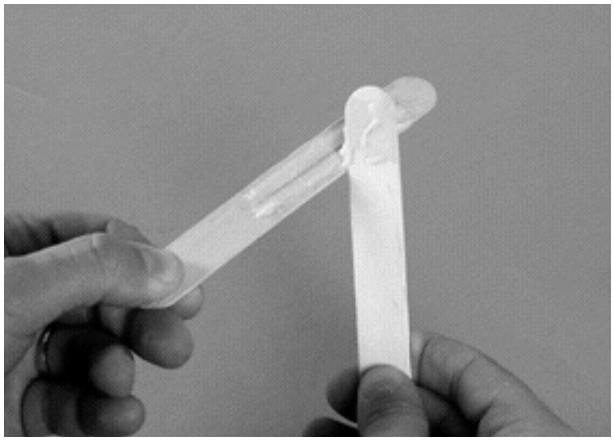


FIG. 4
Excess cream can be recollected from the edges of the tongue depressor, making maximum use of the cream.

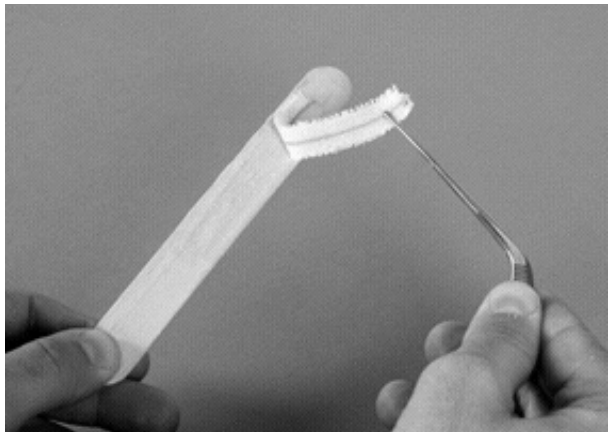


FIG. 5
A neat, well-formed ear wick is obtained.

Conclusion

This new method of preparing an ear wick has proved to be highly effective. We recommend the adoption of this new method, given its simplicity and positive economic impact, in everyday practice.

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