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Discussion on Mr. Smyth's paper: 'Problems of tympanosclerosis in tympanoplasty'

ALAN G. GIBB of Dundee discussing Mr. G. D. L. Smyth's paper said that in his experience the association between tympanosclerosis and cholesteatoma was rare. Cases did occasionally occur but as a rule tympanosclerosis was seen in dry ears. The tympanic membrane was perforated in about two-thirds of cases (open tympanosclerosis) but intact in the remainder (closed tympanosclerosis).

He himself had had considerable experience of the condition and it seemed likely that tympanosclerosis was much more prevalent in some parts of the world than in others. He agreed with Mr. Smyth that the posterior tympanotomy approach was likely to be a useful one in this condition since in his experience the most troublesome cases were those in which tympanosclerosis was widespread and caused ossicular fixation both in the attic and oval window regions. The problem of management of severe tympanosclerosis was a difficult one. Stapedectomy was very successful in dealing with localized deposits in the oval window and was probably preferable to peeling off the tympanosclerotic tissue as the latter manœuvre might render the labyrinth unduly sensitive to subsequent manipulation. On the other hand, if after stapedectomy, the malleus and incus became involved and fixed, a real problem existed for the surgeon.

Unless it was considered certain that the tympanosclerosis was clearly limited to the oval window area it was better to avoid stapedectomy and carry out some form of attic by-pass: this might take the form of transposition of the incus if the stapes could be adequately mobilized or alternatively stapedectomy and a malleus-oval window prosthesis. In certain cases of advanced tympanosclerosis a fenestration was worth considering especially if the patient was opposed to multiple surgical procedures.

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