Role of the Tympanometric Gradient and Acoustic Reflex on Prognosis of Otitis Media With Effusion

Nihat Susaman, Hasan Cetiner

Department of Otorhinolaryngology, Elazig Education and Research Hospital, Elazig, Turkey

ORCID iDs of the authors: N.S. 0000-0002-8890-069X; H.C. 0000-0002-7218-6217.

BACKGROUND/AIMS
Otitis media with effusion (OME) is a major health issue worldwide. Although it is difficult to consider any quantitative measurement in particular to be a herald of clinical recovery in OME, this study aimed to determine the role of tympanometric quantitative values, especially gradient (GR) and acoustic reflex (AR), in patients with OME who are approaching the full healing stage.

MATERIAL and METHODS
Based on the tympanic membrane findings, participants were divided into 2 groups: (A) minimal retraction group and (B) normal group. For each group, the tympanometric quantitative measurements (static compliance [SC], tympanometric peak pressure [TPP], GR, and AR) were obtained and compared statistically. In addition, the relationship of AR with tympanometric quantitative measurements was compared statistically.

RESULTS
The mean GR values in group A (n=66) and group B (n=73) were 157.06±92.85 daPa and 103.60±28.51 daPa, respectively (P=.001). Although no significant difference was found with respect to AR, statistically significant differences were observed with respect to TPP between the 2 groups.

CONCLUSION
In contrast to AR, GR and TPP values were consistent with the examination findings of the tympanic membrane observed in patients with resolved OME progressing to the full healing stage. Thus, these 2 tympanometric quantitative measurements are beneficial for the diagnosis and follow-up of patients with OME.

Keywords: Tympanometry, otitis media, acoustic reflex

INTRODUCTION
Otitis media with effusion (OME) is defined as the presence of fluid in the middle ear without signs or symptoms of an acute ear infection. The tympanic membrane is often cloudy with distinctly impaired mobility, and an air-fluid level or bubble may be visible in the middle ear (1). OME may occur during an upper respiratory infection, spontaneously because of poor Eustachian tube function, or as an inflammatory response following acute otitis media (2). Pneumatic otoscopy has been recommended as the primary method for diagnosing OME because reduced tympanic membrane mobility correlates most closely with the presence of fluid in the middle ear (3). When the diagnosis of OME is uncertain, tympanometry or acoustic reflectometry should be considered as an adjunct to pneumatic otoscopy. Tympanometry with a standard 226-Hz probe tone is reliable for infants 4 months or older and has a good interobserver agreement of curve patterns in routine clinical practice (4). The acoustic reflex (AR) is an involuntary muscle contraction that occurs in the middle ear in response to high-intensity sound stimuli or when the person starts to vocalize. If there is hearing loss, either conductive or sensorineural, of 65 dB hearing level (HL) or greater in the stimulated ear, the reflex will likely be absent (5). The quantification of tympanometric measurements facilitates the development of appropriate standards for comparing tympanometric data among clinics. These measurements include static compliance (SC), volume of external ear canal, tympanometric gradient (GR), and tympanometric peak pressure (TPP) (6).
This study aimed to evaluate whether the otoscopic examination findings are consistent with quantitative tympanometric parameters (especially GR) and AR in patients who had a tympanogram peak in the negative range after a recent history of OME. The study also discusses the role of the quantitative tympanometric parameters (especially GR) and AR as heralds of the healing process in patients with OME.

MATERIALS and METHODS

Enrollment and Study Design
This study enrolled patients who met the study criteria, from January 2017 to March 2019, after approval of the institutional review board. In this retrospective case-control study, patient consent form was not required. Patients aged between 4 and 14 years and with a recent history of OME with a negative peak at tympanogram were included in the study. Patients who had a pure-tone average (500 Hz, 1000 Hz, 2000 Hz, and 3000 Hz) worse than 25 dB of HL, difficulty in obtaining the hearing thresholds, advanced tympanic membrane retraction, middle ear effusion, or neurological and craniofacial anomalies were excluded from the study. Pneumatic otoscopy was performed to exclude fluid in the middle ear and to determine if there was a tympanic membrane retraction. After the inclusion of patients into the study, 2 groups were created according to tympanic membrane findings. The examination of the tympanic membrane was carried out using Barr’s classifications (7), in which the tympanic membrane was divided into areas including anterior to the manubrium malleus (I), posterior superior to the manubrium malleus (II upper), and posterior inferior to the manubrium malleus (II lower) and attic (III). The touching of the eardrum with incus and head of malleus was graded as a first degree (slight) retraction in all areas except in II lower in which first degree (slight) retraction was described as an eardrum dislocated inward without connection of promontory. Patients with normal eardrums were in group A (abnormal tympanic membrane) and 73 were in group B (normal tympanic membrane).

The mean SC was 0.54±0.33 mL in group A and 0.55±0.32 mL in group B (p=.45). The mean values of TPP were -129.33±77.48 daPa and -38.64±57.98 daPa (p=.001) in group A and group B, respectively, and the mean values of GR were 157.06±92.85 daPa and -38.64±57.98 daPa (p=.001) in group A and group B, respectively.

Within the 139 measurements, AR was obtained in 65 measurements (46.8%); however, it was not detected in the remaining 74 measurements (53.2%). The mean GR of the measurements in cases with AR positivity was 114.20±59.99 daPa, whereas the mean GR of the measurements in cases with AR negativity was 141.97±79.46 daPa (p=.001). In group A, 32 out of 66 measurements (48.5%) of AR were positive, and in group B, 33 out of 73 measurements (45.2%) of AR were positive (p=.44). The relationship between AR and tympanometric quantitative parameters is shown in Table 1 for both groups individually and combined.

DISCUSSION

Tympanometry provides an objective assessment of tympanic membrane mobility, Eustachian tube function, and middle ear function by measuring the amount of sound energy reflected back when a small probe is placed in the ear canal (8,9). Tympanometric curves, or tracings, are classified into 3 main types—type A (low probability of effusion) with a sharp peak and normal middle ear pressure, type B (high probability of effusion) with no discernible peak and a flat tracing, and type C (Eustachian tube dysfunction/middle ear pathology) with a discernible peak and negative middle ear pressure (10). In addition to these tympanometric curves, quantitative parameters of tympanometry give valuable information about the condition of the middle ear and eardrum. TPP is the ear canal pressure at which the peak of the tympanogram occurs. The peak...
The AR was observed to be less sensitive to acute otitis media than OME and using AR in the diagnosis of OME was valuable in addition to pneumatic otoscopy (17). When the 2 groups (A and B) were compared for the presence and absence of AR, there was no difference between the groups, and sufficiently positive AR could not be obtained in group B as expected. This could be explained by the presence of subclinical middle ear inflammation in group B even with normal tympanic membrane. In addition, not only a healthy ear but also the whole pathways of reflex arc have to be intact to obtain an AR. Even if the reflex did not show a prognostic value, further studies with broad participation are required to determine its role in OME given that in this study, the cases with positive AR of group B had better GR value than those who had no reflex.

In conclusion, GR and TPP, together, are reliable tympanometric quantitative parameters in the diagnosis and follow-up of patients with OME who are progressing to the full recovery stage. There is no prognostic value of AR for patients with type C tympanograms with minimal tympanic membrane retraction during the healing stage of OME. However, to fully demonstrate the role of AR during the healing stage of OME, prospective studies with a control group are needed. AR positivity depends on many factors; as discussed in this study, the value of GR is the most prominent determinant in obtaining AR. Using GR is important for patients with OME who progress to complete healing.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Firat University (Approval date: 01/29/2000, No: 13281952-903.0799-E.670).

<p>| TRAble 1. Relationship between AR and tympanometric quantitative parameters in group A and group B, both individually and combined |
|-----------------------------------------------|-----------|-----------|-----------|</p>
<table>
<thead>
<tr>
<th>SC</th>
<th>TPP</th>
<th>GR</th>
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<tbody>
<tr>
<td>AR-positive measurements (n=65)</td>
<td>0.56±0.28</td>
<td>-77.43±92.96</td>
</tr>
<tr>
<td>AR-negative measurements (n=74)</td>
<td>0.53±0.36</td>
<td>-85.45±70.42</td>
</tr>
<tr>
<td>P value</td>
<td>.025</td>
<td>.15</td>
</tr>
<tr>
<td>AR-positive measurements in group A (n=32)</td>
<td>0.64±0.36</td>
<td>-12.87±91.21</td>
</tr>
<tr>
<td>AR-negative measurements in group A (n=34)</td>
<td>0.45±0.27</td>
<td>-144.82±59.15</td>
</tr>
<tr>
<td>P value</td>
<td>.012</td>
<td>.025</td>
</tr>
<tr>
<td>AR-positive measurements in group B (n=33)</td>
<td>0.48±0.13</td>
<td>-43.06±82.14</td>
</tr>
<tr>
<td>AR-negative measurements in group B (n=40)</td>
<td>0.61±0.41</td>
<td>-35.00±25.29</td>
</tr>
<tr>
<td>P value</td>
<td>.025</td>
<td>.15</td>
</tr>
</tbody>
</table>

AR: acoustic reflex; GR: gradient; SC: static compliance; TPP: tympanometric peak pressure.
Informed Consent: N/A

Peer-review: Externally peer-reviewed.


Conflict of Interest: Authors have no conflicts of interest to declare.

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REFERENCES