Regarding “Otoacoustic Emissions in Rural Nicaragua: Cost Analysis and Implications for Newborn Hearing Screening”
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It was a pleasure for us to read the article titled “Otoacoustic Emissions in Rural Nicaragua: Cost Analysis and Implications for Newborn Hearing Screening,” by Wong et al., in your esteemed journal. It is a well-written article, and we commend the authors on their remarkable effort. We just recently concluded a study on the effectiveness of otoacoustic emission screening for newborns in our region, which is a rural part of India. We could see certain similarities between the problems faced by the authors and our own experience, and so we would like to share some points that may be relevant to the present discussion.

At present, India lacks a structured national protocol or health policy for neonatal health screening. In response to this lacuna, various institutions have developed their own institution-level protocols based on international norms and guidelines and tailored to the specific needs of their communities. A large institutional study in South India showed an incidence of hearing impairment of 5.6 per 1000 neonates screened, similar to what we found in our institution and also similar to that of the present study. This high incidence necessitates the urgent need for implementation of, at least, tailored protocols to meet the needs of the community.

Studies by Owen et al. and Berg et al. highlight the essential role of public health care workers in neonatal hearing screening. Both these studies employed community health workers to perform neonatal screening at the community level. But as the authors of the present study have suggested, high travel costs can be an important limiting factor, and we faced similar difficulties in our own study. Our suggestion is that community health workers be utilized to regularly encourage and motivate mothers to bring their children to appropriate health centers for hearing screening within the first 3 months of birth, hence avoiding these unnecessary costs.

Achieving 100% coverage of all neonates for hearing screening may not be a possibility in countries without a standard protocol in place at the national level. Hence, it is of the utmost importance to use political will and to influence the country’s politicians to bring in funding and legislature that support the implementation and maintenance of neonatal hearing screening, which would help achieve the dream of complete coverage. To this end, a large-scale multicenter prospective study of the need for neonatal hearing screening with a national-level cost-benefit analysis would surely motivate change at the highest levels.

Davis Thomas Pulimoottil, MS (ENT)
Karthikeyan Padmanabhan, DLO, DNB (ENT)
Department of Otorhinolaryngology and Head and Neck Surgery, Mahatma Gandhi Medical College and Research Institute, SBV University, Pondicherry, India

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References

Commentary on “Tympanoplasty following Blast Injury”
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I wish to address the manuscript entitled “Tympanoplasty following Blast Injury” by Keller et al. The authors retrospectively analyzed the tympanoplasty success rates for
blast-induced tympanic membrane perforations (TMPs) in 254 military personnel (352 operations). The authors concluded that tympanoplasty success rates for blast-induced TMPs are lower than for other common injury mechanisms. However, certain details were not provided, and the conclusions of the study were not convincing.

The authors reported that “clinical follow-up averaged 30 months. Initial surgery resulted in an 82.1% success rate. The mean number of days between the injury and primary tympanoplasty was 197 days. . . . There was a 76% (29 of 38) successful closure rate for attempts at revision of tympanoplasty for persistent perforations.”1 The authors did not sufficiently describe the graft material or the status of the surgeon and compare the respective success rate among the 4 military service branches. The experience of the surgeon is vital to improve the graft intake success rate and hearing results after tympanoplasty. Large perforations are a risk factor for tympanoplasty failure of any other perforation mechanisms.2 Sprem et al3 showed tympanoplasty success rates of 91% with temporal fascia and 92% with perichondrium for blast-induced total or subtotal perforations. Angeli et al4 also reported a 91% success rate for near-total and total perforations of chronic otitis media. In addition, the temporalis fascia will typically degenerate and shrink over time, resulting in reperforation. Cartilage graft is not easily absorbed and can resist changes in middle ear pressure resulting from eustachian tube dysfunction, thereby avoiding reperforation. Peyvandi et al5 suggest that the majority of blast-induced TMPs had poor eustachian tube function. Eustachian tube dysfunction is a predictive factor for the failure of temporalis fascia tympanoplasty. Thus, the authors should evaluate eustachian tube function.

The authors described that “the mean number of days between the injury and primary tympanoplasty was 197 days (range, 3-1627 days)” in the Results section.1 This suggests that some perforations within 3 months postinjury were treated using tympanoplasty. It is known that small and medium traumatic TMPs tend to heal spontaneously. In addition, some authors have observed perforations that healed spontaneously even after 6 months. Using endoscopic techniques, foreign bodies and debris in the middle ear may be removed using microsuction and endoscopic guidance to avoid cholesterolota of the middle ear, after which spontaneous healing can occur. Tympanoplasty is an invasive surgery that requires hospitalization. Growth factors have been used to repair traumatic TMPs, showing an improved closure rate and shortened closure time. Lou et al6 found that the closure rate did not differ between fibroblast growth factor 2 on blast and noninduced TMPs. Thus, topical application of growth factors on blast-induced TMPs should be recommended prior to tympanoplasty.

### References

### About “Polypoid Change of the Middle Turbinate and Paranasal Sinus Polyposis Are Distinct Entities”
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We recently read the article entitled “Polypoid Change of the Middle Turbinate and Paranasal Sinus Polyposis Are Distinct Entities,” by Brunner et al,1 with great interest. They concluded that polypoid change of the middle turbinate (PCMT) is a unique physical finding with clinical associations that distinguish it from paranasal sinus polyposis and that PCMT has greater association with allergic rhinitis. We think that this is very interesting, as it is the first study to compare 2 diseases in which differences in characteristics are unknown. So, we are very grateful for the authors providing excellent information to the readers. However, we want to make some comments about this study.

First of all, we want to point out 3 minor mistakes. (1) In the Results section (lines 7-10), we think that the sentence was incorrectly described on the basis of the data in Table 1. The following sentence is correct: “Inhalant allergy was confirmed in 19 patients in the PCMT group and 15 patients in the [paranasal sinus polyposis] group.” (2) In the second paragraph of