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LETTER TO THE EDITOR

Response to the Letter to the Editor regarding “Comparison of temporalis fascia muscle and full-thickness cartilage grafts in type 1 pediatric tympanoplasties” by Yegin et al. (Braz J Otorhinolaryngol. 2016;82:695–701)[☆]



Resposta à carta à editora sobre “Comparação de enxertos com fáschia do músculo temporal e cartilagem de espessura total em timpanoplastias tipo 1 em crianças” de Yegin et al. (Braz J Otorhinolaryngol. 2016;82:695–701)

Dear Editor,

We would like to thank Dr. Zheng-cai Lou for valuable and precise comments on our article.¹ Firstly, the main outcomes of type 1 pediatric tympanoplasty are the graft success rates and postoperative hearing outcomes. Our results indicate that the graft success rate was 92.1% of the cartilage group compared with 65.0% of the temporal fascia group, respectively. In the fascia group, preoperative ABG was 33.68 ± 11.44 dB and postoperative ABG was 24.25 ± 12.68 dB. In cartilage group, preoperative ABG was 35.68 ± 12.94 dB and postoperative ABG was 26.113 ± 12.87 dB. The anatomical success rate of cartilage group was significantly better than fascia group ($p < 0.01$). There was no significant difference among functional outcomes between fascia and cartilage groups ($p > 0.05$). The thickness of tragal cartilage was accurately measured by a micrometer and recorded intraoperatively. A regular whole-

length bar of tragal cartilage was excised and the thickness of tragal cartilage was measured. Measurement of thickness was performed by the same surgeon (YY). All measurements were repeated by the second surgeon (MÇ) to avoid inter-observer variations. Three measurements were performed to avoid discrepancy and incorrect results. Measurements consisted of superior, middle and inferior parts of tragal cartilage. The average thickness of tragal cartilage was accepted as the average of three measurements. The total average thickness of tragal cartilage was 0.693 ± 0.094 mm in males and 0.687 ± 0.058 mm in females. To our knowledge, the present study is the first study of measuring thickness of tragal cartilage in pediatric tympanoplasty.²

Dr. Zheng-cai Lou stated that “We believed that a “retrospective review” and “randomly allocated” are contradictory.” in his comments on our study design. Of course, you are right. But, in discussion, explanation of this condition was putted in an appearance. Honestly, there is no consensus on the selection of graft materials for tympanoplasties; it depends entirely on surgeon experience and preferences. In our clinic, the selection of graft materials for pediatric tympanoplasties depends entirely on surgeon experience and preferences. It means utilization of temporalis fascia muscle or tragal cartilage grafts is randomly allocated by the surgeons. It is not the purpose of our study design to determine the terms of selection of the graft materials. Therefore, for this study, there was no contradiction. We agree with you about the further prospective studies, with random control, a larger sample size and longer follow-ups are needed to compare the anatomical and functional outcomes of various cartilage types.

For your other comments on exclusion criterias, you are right and we would like to thank you for bringing this to our attention. Granulation tissue may affect the success of pediatric tympanoplasties, but no studies to date have reported about this condition. In our patients’ charts, we do not record the presence of granulation tissue for pediatric tympanoplasties.

Although data on the selection of graft materials for pediatric tympanoplasties continues to rise, there is at present no consensus on the selection of graft materials for tympanoplasties.³ However, we have also planned to compare the anatomical and functional outcomes of various graft types (pericondrium grafts, fascia grafts, various cartilage graft [conchal and tragal cartilages]) and differing

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thicknesses of cartilage grafts in pediatric tympanoplasties in future.

Conflicts of interest

The authors declare no conflicts of interest.

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