

# Chronic Otitis Media in "ENT" and Cleft Lip and Palate Surgery

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## Abstract

The purpose of this study was to examine the epidemiological, clinical, and therapeutic features of chronic otitis media in our setting. In patients with unilateral complete cleft lip and palate, the study compared the short-term results of simultaneous repair of the cleft lip and cleft hard palate with a vomer flap to cleft lip repair alone (UCLP). 35 individuals with unilateral complete cleft lip and palate who had simultaneous repair of their cleft lip and cleft hard palate with vomer flaps participated in a prospective observational study. The cleft soft palate was fixed after three months. The distance between the posterior border of the cleft hard palate and the cleft alveolus was measured during the first and second procedures. Additionally tracked were postoperative problems, blood transfusion needs, and the length of surgeries. For the treatment of cleft lip and palate in UCLP patients, simultaneous repairs of the cleft lip and closure of the cleft hard palate with vomer flaps are simple to carry out and very effective. No transfusion of blood was required. The soft palate was easier to close, the procedure took less time, and there was less possibility of nasal fistula formation due to the much reduced gaps at the posterior border of the hard palate and the alveolar cleft.

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**Keywords:** ENT surgery; Cleft palate; Otitis media; Hearing loss; Clinical and therapeutic

## Introduction

The pathophysiology of chronic otitis media (COM) is still common. Particularly in our regions, which are characterized by low medicine and long wait times for specialist consultation referrals, it might evolve through major problems and irreversible harm. The problem with the COM in underdeveloped nations continues to be found in both its diagnostic and therapeutic approaches. Analysis of the epidemiological, clinical, and therapeutic characteristics of this illness at the University Hospital of Ouagadougou was the goal of this study. The structure and operations of the mouth cavity are impacted by congenital orofacial malformation, greatly altering its characteristics. As a result, these anomalies might have an impact on the environment's microbiota. The most frequent congenital developmental abnormality of the mouth cavity is an orofacial cleft [1].

Connectivity between the oral and nasal canals that extends from the upper lip and nasal vestibule to the end of the soft palate is a characteristic of neonates with complete cleft lip and palate (CLP). Natural sucking is negatively impacted by this problem, and it may even make it difficult to swallow food. Additionally, newborns and children with orofacial clefts need specialised care to maintain adequate hygiene of the incisive bone, nasal passages, and oral cavity with a focus on getting ready for upcoming surgical operations. The lips and hard palate remain connected in a less severe form of orofacial cleft known as cleft soft palate (CSP). Patients with this deformity experience dysmorphia of the oral cavity, which drastically reduces communication between the dorsal part of the mouth cavity and the nasal cavity when compared to CLP [2].

Previous research has shown that people with orofacial clefts are more likely than children without clefts to acquire periodontal and dental caries. Additionally, in participants with various forms of cleft palate, variations in the quantity and makeup of oral microbiota have

been noted during deciduous or permanent dentition as well as a result of surgical or orthodontic therapy [3].

Babies with cleft palate have an environment that is different from that of healthy newborns due to both aberrant morphology and inappropriate function of the mouth cavity. Therefore, the oral microbiome may be impacted by these anomalies. On the early microbiome in newborns and infants with various forms of cleft palate, few reports have been published. Comparing the oral microbiota of newborns in the CLP and CSP groups was the study's main objective. The second goal was to examine how the oral microbiome changed in people with complete CLP and an age-matched CSP group during infancy and at the gum pad stage before surgery [4].

## Materials and Method

The 79 patients with COM in this prospective descriptive research ranged in age from 6 months to 75 years, these cases were gathered in the ENT department of the University Hospital (CHU-YO) of Ouagadougou from March 1, 2009, to February 29, 2010. During the investigation, 850 ears were inspected. All COM patients who visited the clinic for consultation during the specified time frame and gave their informed consent were included. The following criteria were used to make the diagnosis of COM: pure tone threshold audiometry reveals

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a hearing loss, alterations in the eardrum, eardrum perforation or not, and persistent inflammation of the middle ear lasting more than three months. A follow-up control check was performed on patients 15 days, 30 days, 60 days, and 90 days following treatment. Controls assessed regional alterations (ending of otorrhea, aspect of the eardrum, and the bottom case, with research of complications). We created a data collecting sheet that took into consideration the patient's age, gender, and medical history as well as information about the clinical examination, additional research, treatment, and evolution [5].

## Discussion

In our experience, 79 chronic otitis media patients-or 0.96% of consultants-were examined in a calendar year. After a year of surveying, Morocco discovered 103 cases annually, Seoul 220 cases annually, and Turkey 289 cases. We have a low rate. Given our current state of exercise, where there are few medical facilities, trained personnel, and technical facilities, it is impossible to pinpoint the exact incidence of this ailment. As a result, there is a case underreporting problem in our setting [6]. The months of December and the time frame of March to June saw the highest rates of COM instances. This corresponds to the time of year in Burkina Faso when the cold, dry, dusty Harmattan winds weaken the mucosa and encourage acute respiratory infections, especially acute otitis media (AOM). With a prevalence of 73.41% of instances, it predominates the background, Due to the typical otitis episode lasting nearly three times as long in cold weather as it does in warm, it is crucial in the development of COM in France. Thus, the seasonal influence plays a crucial role in the development and upkeep of COM [7].

With a frequency of 40.50%, the age group from 0 to 15 years was the well-represented in our study. These findings are close to those of David and Peter in the US, who found that the rate for children between the ages of 0 and 15 was 39%. We concur with these writers that a child's immune immaturity at this age, combined with the ENT area's anatomical characteristics, predisposes them to AOM and, consequently, to COM. In our study, the average wait time for a specialised consultation was six months, and for more than 25% of patients, it was ten months. Due to the importance of self-medication and the dominance of conventional treatment in our society, the lack of third-party payment (patients are responsible for paying the whole cost of medical care) and the delay in specialist consultation are both possible explanations. The minimal impact of this disease's symptoms, which in our areas acts as a trivializing element could be added [8].

In our series, simple COM was most prevalent (71.02%), with a very central perforation (61.73% of instances). These findings align with those of other writers, such as Home et al. from Denmark, who reported an 86% frequency of central perforation as the predominant. In our setting, COM with effusion appears to be less common (24.30% of cases). However, many of these straightforward cases of COM could actually be genuine COM, as evidenced by effusions that are superinfected and open. Only 4.70% of cases involved cholesteatoma COM. These findings suggest confirming that cholesteatoma are uncommon in our setting. However, for us, this scarcity is relative because many cases undoubtedly go unreported when an otology consultation is conducted without the use of a microscope. Additionally, many COM carriers in our underdeveloped nations fail to consult an ENT. Additionally, some superstitions persist, such as "an ear flowing along hears very well." In any case, we need to be aware of the cholesteatoma COM's specific gravity [9].

The most prevalent contributing factor identified was in-ear instillation of conventional products (46.09%), followed by rhinitis

(26.09% of cases). Due to their chronic impairment of tubal function, rhinitis and nasopharyngitis, two well-known predisposing variables, are taken into consideration in the development of COM. However, in this instance, we should first place the responsibility on the traditional products' (46.09%) instillation, which are of a poorly recognized chemical nature. They'll probably make it more likely that large lesions will form and that the condition will become chronic. Unfortunately, this therapeutic use is prompted by the patients' poor purchasing ability, the influence of sociocultural customs (such as pond baths), and a disregard for the risks involved [10].

Medical and surgical care is used to treat COM. It not only slows down the inflammatory and infection processes but also guards against otogenes problems. Topical antibiotics and anti-inflammatory medications are crucial in 88.61% and 87.34% of patients in our series, respectively. These findings agree with the data from the literature. The most frequently performed surgical procedures in our series were mastoidectomy, followed by Paracentesis and myringoplasty. This surgical procedure addressed four key issues: cholesteatoma, simple open-spandrel COM, infectious problems, and otitis media with effusion. In this most recent instance, cholesteatoma removal in its entirety is still the required course of action [11].

In our study, 86.35% of cases had a good response to treatment. Early intervention and high-quality technological resources are significant advantages for the prognosis. However, in our series, Endotemporal problems are common. In our investigation, the functional sequelae were predominately deafness, which had significant socioprofessional ramifications. A crucial component of the management of COM is the management of these sequelae [12].

## Conclusion

As a rather widespread illness in contemporary society, COM continues to be a problem for public health that is frequently misunderstood. Diagnostic and therapeutic challenges are brought on by inadequate technology infrastructure in developing nations like ours. Without a doubt, we should put our attention on prevention through increased public awareness, proper treatment for upper respiratory infections, and early AOM diagnosis.

In many ways, global surgery is still in its infancy. In order to maximise the benefits of these initiatives for healthcare systems in LMICs, it is crucial that we continue to learn from the advantages and disadvantages of the vertical and horizontal approaches as we advance global CLP care. We acknowledge the continuous need for vertical humanitarian missions and value the contributions made by numerous cleft care organizations. In fact, the cleft care community is now in a position to contribute substantially to enhance surgical capacity and promote quality of treatment due of the successes of cleft missions. The methods used to deliver care will advance as financing for global surgery procedures becomes more readily available and as a means of attaining the best results. A diagonal approach to CLP care is a method of reaching the goal of becoming plastic surgeons thought leaders in global surgery at this pivotal time.

## Conflict of Interest

None

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