THRESHOLD POLICY – T7b
GROMMETS IN ADULTS

Policy author: Ipswich and East and West Suffolk CCG with support from Public Health Suffolk.

Policy start date: July 2012

Previous review dates September 2014

February 2017

Next review date: February 2020

1. Policy Summary

1.1 This policy does not apply to anyone under 19 years of age. For the use of grommets in children, please see policy T7a.

2. Eligibility Criteria

2.1 IES and WS CCGs will only fund grommet insertion in adults (aged 19 and over) when the following criteria are met:

a) Insertion of grommets as part of a more extensive surgical procedure or

b) Severe retraction of the tympanic membrane and in the expert view of the consultant that this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma or

c) Eustachian tube dysfunction that prevents the commencement or completion of hyperbaric oxygen treatment or

d) acute or chronic otitis media with risk of complications of facial palsy or intracranial infection e.g. meningitis or

e) As a treatment for Meniere’s disease or

f) In the case of conditions e.g. nasopharyngeal carcinoma, ethmoidal cancer, maxillectomy, olfactory neuroblastoma, sinonasal cancer, and complications relating to its treatment (including radiotherapy), if judged that the risks outweigh the benefit by the responsible clinician or

g) There is severe pain due to air pressure changes when flying or in hyperbaric treatment. The severity and frequency of flying should be discussed with the patient and balanced against the possible complications associated with grommets

2.2 Of note: In cases of otitis media with effusion in adults, grommets are not routinely funded as unlike in children where the outcome of OME is generally good, this is not clear in adults
3. **Background to the Condition**

3.1 The insertion of grommets, or ventilation tubes, is a common procedure: it may be used to treat otitis media with effusion (OME), which may be idiopathic, atopic or related to nasopharyngeal carcinoma and its treatment. Additionally it is used as a possible treatment for Ménière's disease, for the relief of aural symptoms related to flying, as a part of more extensive ear surgery or as a route of drug delivery to the middle ear.

3.2 A limited literature review failed to find any high quality evidence of the effectiveness of grommets in adults. These recommendations are based almost exclusively on case series.

3.3 **Otis media**

   a) Adult OME may be secondary to sinusitis, nasopharyngeal malignancy or be idiopathic in nature.\(^1\) It has been suggested that the use of grommets in adults (as opposed to children) in associated with worse outcomes, with increased likelihood of symptom recurrence. One case series\(^2\) reported 96% recurrence of symptoms following grommet insertion (n = 50, follow-up 27 months); another\(^3\) reported 35% recurrence (n = 53, follow-up 15-27 months).

   b) According to NICE Clinical Knowledge Summaries (CKS), there is insufficient evidence from relevant clinical trials of evidence reviews on recurrent acute otitis media (AOM) and the effective treatment for adults with grommets (ventilation or tympanostomy tubes). ‘Taking an ear swab for culture and sensitivity is considered reasonable’, based on what is considered to be good clinical practice from expert opinions\(^6\).

3.4 **Nasopharyngeal cancer**

With regards to patients with effusion secondary to nasopharyngeal cancer (and radiotherapy as treatment for this condition), advice seems to be conflicting. One case series\(^4\) (n = 30) concluded that grommet insertion resulted in a significant improvement in hearing, though they also noted increased complications associated with grommets in this patient group. The time course of the improvement is not clear. Another case series\(^5\) (n = 163) commented on significant side effects of ototorhoea and perforation, and concluded that “myringotomy and grommet insertion should not be routinely offered to NPC patients with middle ear effusion”. Another group\(^6\) compared grommet insertion with repeated myringotomy (n = 100). They noted a significant increase in middle ear complications and concluded that “grommet insertion in contraindicated in post- irradiation OME”. A non-blinded RCT\(^7\) assessed the role of grommets inserted prior to radiation in patients with NPC. They found no difference in hearing over 4 years of follow-up.

3.5 **Retraction pockets**

We were unable to identify any evidence relating to grommets as a sole treatment for retraction pockets (as opposed to, for example, excision of the pockets and grommet insertion).

3.6 **Evidence for use of grommets for pain on flying:**

There is one description of a systematic evaluation of the management of otic barotrauma using modified intravenous cannula. Zhang et al 2013 showed that using a modified 24- gauge IC cannula for tympanotomy tube placement provided middle ear ventilation. 191 tubes were placed for otalgia because of hyperbaric oxygen therapy, 58 tubes were inserted for air travel
prophylaxis and 22 tubes were placed for management of otic barotrauma post-flight. All the patients who had this procedure for prophylaxis experienced regular otic barotrauma symptoms during air travel prior to tube placement. All patients were reviewed at 6 weeks post procedure. This technique worked effectively in 99%, though after 6 weeks 88% of the tubes were found to be extruded. They concluded that given the safety, effectiveness, low risk of complications it provided a simple yet effective therapeutic option for otic barotrauma.

3.7 Ménière’s Disease

A case series\(^8\) of 22 patients with unilateral Ménière’s disease which was ‘intractable to medical treatment’ who were treated with grommets showed improvement in patient symptoms in 68% (patient reported symptoms). A case series\(^5\) of seven patients treated with grommets for Ménière’s disease reported ‘substantial’ benefit in symptoms in 5 at 24 months and 4 patients at 42 months. In a series\(^10\) of 28 patients suffering Ménière’s disease which was refractory to medical treatment, it was found that 82% did not have recurrence over two years of follow-up. It is also noted that ventilation tubes may be a means of drug delivery (gentamicin, dexamethasone) in treatment of Ménière’s disease.

4. Rationale to the Decision

4.1 Literature from the NICE, Cochrane database and other scholarly article sources were used to provide rationale for the policy. Furthermore this policy is in line with other CCGs such as West Sussex CCG and Doncaster CCG.

5. References


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