If surgical treatment of chronic otitis media will affect the client’s hearing, include this information in preoperative teaching. Teach the client and family how to use alternative means of communication if this will be necessary postoperatively. When an assistive device is ordered, teach the client and a family member about its use.

**THE CLIENT WITH OTOSCLEROSIS**

Otosclerosis is a common cause of conductive hearing loss. Abnormal bone formation in the osseous labyrinth of the temporal bone causes the footplate of the stapes to become fixed or immobile in the oval window. The result is a conductive hearing loss.

Otosclerosis is a hereditary disorder with an autosomal dominant pattern of inheritance. It occurs most commonly in Caucasians and in females. The progressive hearing loss typically begins in adolescence or early adulthood and seems to be accelerated by pregnancy. Although both ears are affected, the rate of hearing loss is asymmetric. Because bone conduction of

---

**NURSING CARE OF THE CLIENT HAVING EAR SURGERY**

**PREOPERATIVE CARE**

- Review Chapter 7 for routine preoperative care.
- Assess the client’s hearing or verify documentation of preoperative hearing assessment. These data are important in evaluating the results of the surgical procedure.
- Agree on a means of communication to be used after surgery. Hearing may be impaired after surgery.
- Explain that blowing of the nose, coughing, and sneezing are restricted to prevent pressure changes in the middle ear and potential disruption of the surgical site. If the client needs to cough or sneeze, leaving the mouth open minimizes pressure changes in the middle ear. Providing teaching and the opportunity to practice before surgery promotes the client’s cooperation in the postoperative period.

**POSTOPERATIVE CARE**

- Review Chapter 7 for routine postoperative care.
- Assess the client for bleeding or drainage from the affected ear. Infection and hemorrhage are possible complications.
- Administer antiemetics as ordered to prevent vomiting. Vomiting may increase the pressure in the middle ear, disrupting the surgical site.
- Elevate the head of bed and have the client lie on the unaffected side. This position minimizes pressure in the middle ear.
- Assess for vertigo or dizziness, especially with ambulation or movement in bed. Avoid unnecessary movements such as turning. Take measures to ensure safety when the client gets up and ambulates. Surgery on the ear may disrupt the client’s equilibrium, increasing the risk of falling.
- Assess the client’s hearing postoperatively. Stand on the client’s unaffected side to communicate and use other measures such as written messages as needed for effective communication with the hearing-impaired client. Reassure the client that decreased hearing acuity immediately after surgery is expected. Hearing improvement, if an expected result of the ear surgery, typically does not occur until ear plugs are removed, and edema and drainage at the operative site have resolved. If no reconstruction of the middle ear is done or the cochlea is involved, permanent hearing loss in the affected ear may be an expected result.
- Remind client to avoid coughing, sneezing, or blowing the nose. These increase pressure in the middle ear.

**Client and Family Teaching**

- Provide instructions for home care.
  a. To prevent contamination of the ear canal, avoid showers, shampooing, and immersing the head until the physician says you can do so.
  b. Keep the outer ear plug clean and dry, changing it as needed. Do not remove inner ear dressing until the physician so orders.
  c. Avoid blowing the nose; if you need to cough or sneeze, keep the mouth open.
  d. Do not swim or dive without physician approval. Check with the physician regarding air travel.
  e. Meclizine hydrochloride (Antivert) or other antiemetic/antihistamine medication may be necessary for up to 1 month following surgery.
  f. Fever, bleeding, increased drainage, increased dizziness, or decreased hearing after discharge may indicate a complication. Notify the physician if any of these occur.

---

blood supply to the stapes, causing its destruction and conductive hearing loss. Cholesteatomas are benign and slow-growing tumors, which can enlarge to fill the entire middle ear. Untreated, the cholesteatoma can progressively destroy the ossicles and erode into the inner ear, causing profound hearing loss.

Systemic antibiotics are prescribed for exacerbations of purulent otitis media. Tympanic membrane perforation is repaired with a tympanoplasty to restore sound conduction and the integrity of the middle ear. A cholesteatoma may require radical mastoidectomy to remove the tympanic membrane, ossicles, and tumor. The mastoid air cells and middle ear are converted into an open cavity, which can be inspected and cleaned as necessary.

As with other complications of acute otitis media, a priority of nursing care is prevention of chronic otitis media and cholesteatoma. Clients with chronic otitis media need to understand various treatment options and their risks and benefits, as well as the long-term risk of not treating a perforated tympanic membrane. They are also taught how to instill ear drops, to clean the external auditory meatus, and to not irrigate the ear when the tympanic membrane is perforated or if they think it might be.