SUMMARY

Myringoplasty is a well-known operation to all ENT surgeons.

The first surgical closure using autograft (a full thickness free skin graft) was performed by **Berihold** in 1878 and the introduced the word 'Myringoplasty'. **Wulstein and Zoellner** popularised myringoplasty technique in 1951 and with improved optics and microsurgery it is still practiced in modem days.

Various graft material has been used since that time are skin, amniotic membrane, mucous membrane, dura mater, cornea, periosteum, perichondrium, vein, adipose tissue and temporalis fascia, temporalis fascia has become the most popular grafting material.

Many techniques of myringoplasty have been, published in the literature. The most widely accepted techniques for grafting in myringoplasty are the underlay or medial grafting and the overlay or lateral grafting. It could be concluded that both techniques have high success rates. The question addressed is whether differences in success rates in comparative studies may reflect the surgeon's preference for a particular technique.

Fat plug myringoplasty is another reliable technique for the closure of small and medium-sized perforations. The grafting results showed excellent long-term durability. Given the simplicity of the technique, its short duration, and the favourable hearing results, fat graft myringoplasty should be considered the procedure of choice in patients with suitable perforations.

Cartilage myringoplasty is another procedure that has shown to achieve good anatomical and audiologic results. Its more rigid quality tends to resist resorption and retraction, even in the incidence of continuous eustachian tube dysfunction. Cartilage was first introduced in middle ear surgery for management of retraction pockets and more recently, for the reconstruction of the tympanic membrane in cases of recurrent perforation with encouraging results

The overall success of tympanic membrane repair varies greatly. To some degree, this reflects patient selection and experience of the surgeon. Even in the best hands, a percentage of failure, is present either immediate or delayed Various factors have been implicated to affect the results of the reconstructive surgeries. .Some of these factors include the functional status of Eustachian tube, the size of mastoid air cell system, the condition of middle ear mucosa and the duration of disease.

The common causes of immediate failure were graft infection, necrosis and poor anterior adaptation of the graft in decreasing order. Late re-perforations were attributed to insidious atrophy of the tympanic membrane or episodes of acute otitis media.

For putting standard outcome measures we need studies with longer follow-up times. The solution of this problem lies in improving the communication between physicians. Pre-operative patient counseling that stresses the importance of follow-up may help as well.