The contribution of risk factors to the effect of early otitis media with effusion on later language, reading, and spelling

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A cohort of 948 children who were screened for otitis media with effusion (OME) from the ages of 2 to 4 were studied for language, reading, and spelling at 7 years of age. The effects of OME in combination with single risk factors and with increasing numbers of risk factors were investigated. An interaction with an additional risk factor was found only for gender and OME, with boys' spelling influenced negatively by a history of OME. OME in combination with preterm birth and low birthweight also appears to put children at risk for later language and educational problems. Although a negative linear relation between the number of risk factors and later functioning was found, it is suggested that OME, even when combined with a number of other risk factors, produces only minor effects on later language, reading, and spelling.

Otitis media with effusion (OME) is one of the most common diseases in early childhood. It is also considered a risk factor for later speech, language, and associated learning problems, because it is accompanied by a loss of conductive hearing (Silva et al. 1986; Friel-Patti and Finizio 1980; Schilder et al. 1993a). The results of the many studies into the relation of OME to later language and educational problems are nevertheless conflicting. In recent prospective studies, the association of OME with later language and educational problems has been found to be fairly weak (Hubbard et al. 1985; Louw et al. 1988; Friel-Patti 1990; Roberts et al. 1991, 1994; Gravel and Wallace 1992; Grieveink et al. 1993; Schilder et al. 1993a; Peters et al. 1994; Paradise et al. 1995). Whenever there are detrimental effects of early OME at school age, they appear to be of little practical importance (Roberts et al. 1991, 1994; Grieveink et al. 1993; Peters et al. 1994; Louw 1995). Most children with OME appear to overcome the short-term effects of OME as soon as the disease disappears, even when the OME has been long-lasting. These results also do not change when the frequency of the OME and the pattern of its recurrence are taken into account (Grieveink et al. 1993, Peters et al. 1994, Roberts et al. 1994). In other studies, however, a major effect of OME on later language and learning has been found (Silva et al. 1986, Tede et al. 1986). In search of an explanation for these differences, it has been suggested that the effect of OME on later language and learning may be the cumulative effect of a number of risk factors (Rapin 1979, Menyuk 1980, Bishop and Edmundson 1981, Louw et al. 1988, Penre et al. 1988, Roberts and Schule 1990, Roberts et al. 1991). Some authors (Roberts and Schule 1990, Roberts et al. 1991) suggest that it is important to consider those variables that may potentially contribute to the effects of OME as well. In this study, it is assumed that most children can cope with OME and that difficulties may most often arise in the presence of other risk factors. If the negative effects of OME arise from its coincidence with other risk factors, one can expect to find only small effects of OME in a population where the incidence of such risk factors is low. Conversely, one can expect to find a relatively large effect of OME in a population with a high incidence of the risk factors and a history of OME. The data from a specific group of children in the Nijmegen Otitis Media Study (Grieveink et al. 1993, Peters et al. 1994) were then analysed to test this hypothesis.

Several factors have been suggested to produce a lower level of language ability and educational attainment in general and in relation to OME in particular. Such variables are socio-economic status, sex, the intelligence level of the children, gestational age and birthweight, and a first language other than Dutch. In a number of studies, the role of a low socio-economic status in placing a child at risk is emphasized (Rapin 1979; Menyuk 1980, 1986; Hopman-Rock et al. 1980; Roberts et al. 1980, 1986, 1991, 1994; Louw 1993). Tede et al. (1984) compared a high and low social group and found only a relation between OME and lower language scores for the higher social group. With regard to sex as a risk factor, boys have generally been found to score lower on language-development tests than girls in general and in association with the occurrence of OME in particular (Silva 1980, Hopman-Rock et al. 1988, Alfred 1990 Louw 1993). Low intelligence is associated with poor language scores and reading difficulties (Silva et al. 1983). Preterm birth and a low birthweight (LBW) have also been found to be risk factors for later functioning (Largo et al. 1989). Heregard
The validity of the tympanogram had been tested in pilot studies of 2 and 4 years (Zielhuis et al. 1989b). The reliability and validity of the tympanogram were assessed on nine occasions at 3-month intervals between the ages of 2 and 4 years (here called OME subjects) and children who had never had bilateral type B or C tympanograms (control subjects) were invited to have their language, reading, and spelling achievement measured: 305 (78%) of the 385 children invited were studied in this way. Three groups of subjects were then formed: untreated OME subjects (N=151), treated OME subjects (N=37) and control subjects without OME (N=82). In addition, 35 children whose first language was other than Dutch ('L2 children') were studied: 20 non-treated OME children, 1 treated child, and 14 control children.

**MATERIALS**

Various tests of language ability were used to evaluate various aspects of language ability (Bachman et al. 1988, van Bon 1992). Two subtests from the Taaltests voor Kinderen (Language Tests for Children) (van Bon 1982) were used to establish general language ability. The morphological Word Forms Production test was used because it is a good indicator of a general language factor (van Bon 1992), and because morphological competence has been demonstrated to be sensitive for abnormal language development (Morehead and Ingram 1973, Wig et al. 1973, Johnston and Short 1976, Vogel 1983). The Concealed Meanings test is receptive in nature, and concerns the child's understanding of the non-explicit content of sentences; there is evidence that children with hearing impairments have problems in recognizing such information (Quigley and Paul 1989). These two tests load on different factors (van Bon 1984).

Each of the 35 items on the Word Forms Production test consists of two sentences. A simple form of the relevant word is used in the first sentence, while the experimenter points at a picture. In the second, open-ended, sentence, the induced form of the same word has to be provided by the subject while the experimenter points at a second picture. The total number of correct answers is counted.

In the Concealed Meanings test, the child has to match one of two pictures to a sentence that presupposes or implies certain information. This test consists of 33 items, and the total number of correct choices is counted.

Three tests of phonological ability were selected, because phonological ability is assumed to be highly susceptible to the effects of the hearing loss associated with OME, and phonological ability appears to play a crucial role in learning to read and write (Staunich 1986). Tests for phonemic segmentation, sound blending, and auditory discrimination were used.

The children were asked to divide spoken words into their constituent phonemes in the Phonemic Segmentation test, and to blend separate phonemes into a whole word in the Sound Blending test. Both tests consisted of 30 monosyllabic words, 15 real words, and 15 pseudowords created by changing the vowels of the real words. The pseudowords are pronounceable.

**Method**

**SUBJECTS**

A birth cohort of 1439 children born between September 1, 1982 and August 31, 1983 in Nijmegen, a town of 145,000 inhabitants in the Netherlands, formed the basis of this study. Of these children, 1328 were screened for OME by tympanometry on nine occasions at 3-month intervals between the ages of 2 and 4 years (Zielhuis et al. 1989b). The reliability and validity of the tympanometer had been tested in pilot studies (Zielhuis et al. 1989b). The tympanograms were classified as type A, C1, C2 or B, according to a modification of Jerger's (1976) method. Type A indicates normal compliance of the tympanic membrane, type C1 and C2 indicate various degrees of negative middle ear pressure and reduced compliance of the tympanic membrane. A type B tympanogram (i.e. a flat one) was considered indicative of OME.

On follow-up when the children were 7 to 8 years old, 131 of the 1328 children had moved to another region, and the parents of 37 children declined to participate after the preschool screening. The remaining 1160 children were invited to participate in this follow-up study between September 1990 and February 1991; 946 attended. All 946 children were examined by otomicroscopy, tympanometry, and audiometry. An ear, nose, and throat history was taken of the period between the last preschool screening and the present study. Audiological and otological characteristics of the whole group are described elsewhere (Schilder et al. 1993b, 1994). Children who had had bilateral B tympanograms on at least two consecutive occasions between the ages of 2 and 4 years (here called OME subjects) and children who had never had a bilateral type B or C tympanogram (control subjects) were invited to have their language, reading, and spelling achievement measured: 305 (78%) of the 395 children invited were studied in this way. Three groups of subjects were then formed: untreated OME subjects (N=151), treated OME subjects (N=37) and control subjects without OME (N=82). In addition, 35 children whose first language was other than Dutch ('L2 children') were studied: 20 non-treated OME children, 1 treated child, and 14 control children.

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but meaningless sequences of speech sounds that obey phonological rules of Dutch word formation. The contrast between real words and pseudowords makes it possible to examine the effect of lexical knowledge on word recognition (Bryant and Bradley 1980). The number of correct answers was counted.

The Auditory Discrimination test was constructed following the procedure of Wepman’s test (1973). Children were asked to judge whether or not two monosyllabic spoken words or pseudowords were the same. Like pairs consisted of the same word twice; unlike pairs consisted of minimally contrasting words such as maas (mouse) and laas (house). The test had 46 items. 23 pairs of real words and 23 pairs of pseudowords; 10 pairs were like words and 36 pairs were unlike. The items were recorded on tape by a speech language pathologist, and the number of correct judgments was counted.

Because of the limited time available for testing, reading tests were restricted to the word and sentence level. Three reading tests were used to test word decoding ability and comprehension of written sentences: the One-Minute test, the Word Recognition test and the Sentence Verification test.

The standardized One-Minute test (Brus and Voeten 1970) is frequently used to measure decoding ability, and is highly correlated with tests for reading text aloud (Monners 1987). Words ordered according to difficulty were read aloud as fast and as accurately as possible. The number of words read correctly within one minute constitutes the test score.

The Word Recognition test (adopted from van den Bosch 1981) uses real monosyllabic words and monosyllabic pseudowords consisting of four different orthographical structures. All of the words can be read correctly by applying simple grapheme-phoneme correspondence rules. An Apple II GS computer with 2 monitors (one for the subjects and one for the experimenter), a voice-key and a microphone were used to present the words and register the response. The real words were all ones frequently used in children’s literature (Staphorsius et al. 1988). Pseudowords were created by replacing the vowel graphemes of the real words with others of the same grapheme class. Words were selected that could be written correctly by applying simple phoneme-phoneme correspondence rules. The child was requested to repeat each word correctly and then to write the word.

The Coloured Progressive Matrices test (Raven 1965, van Bon 1986) was administered as a non-verbal test of intelligence.

Parents were asked to complete questionnaires about their own educational level, information about the first language of children, preterm birth, and birthweight was collected from questionnaires used in the first part of the Nijmegen Otitis Media Study, when the children were 3 years of age.

**PROCEDURE**

The follow-up data were collected between September 1990 and February 1991 at the Department of Otorhinolaryngology of the Nijmegen University Hospital, in order of the subjects’ birthdates.

The reading and spelling tests were administered by two of us (SAFP and KH O), who were unaware of the OME histories of the subjects. All subjects were tested individually. All tests were administered in the same order. With parents’ permission, questionnaires were sent to the children’s teachers.

**ANALYSES**

To study the effects of OME in combination with risk factors on language ability and educational attainment, two approaches were followed. First, it was expected that the performance of OME subjects would be lower if an additional risk

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### Table 1: Tests used in MANOVAs

<table>
<thead>
<tr>
<th>Language tests</th>
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<tr>
<td>Word Forms Production test</td>
<td>Grapheme knowledge test</td>
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<tr>
<td>Concreteness Meaning test</td>
<td>Spelling</td>
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<tr>
<td>Phonological ability</td>
<td>Spelling test, using real words and pseudowords</td>
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<td>Phonemic-Segmentation test, using real words and pseudowords</td>
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<td>Sound Blending test, using real words and pseudowords</td>
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<tr>
<td>Auditory Discrimination test, using like pairs of real words and pseudowords</td>
<td>Word recognition test, using real words and pseudowords</td>
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<td>and unlike pairs of real words and pseudowords</td>
<td>Sentence verification test, using correct and incorrect sentences</td>
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Otitis Media and Risk Factors. *Sylvia A F Peters et al.*, 33
factor were present. To test this primary hypothesis, four groups of subjects were considered in a two-by-two design, according to level of subjects' risk (high and low) and the presence of OME (OME subjects compared with controls). The hypothesis was that the effect of OME is greater in subjects with an additional risk than in subjects without one. Thus an interaction effect was defined. The hypothesis assumed that there is indeed a risk factor. This was verified by testing the effect of the risk factor in the control subjects.

Another question was whether OME subjects with an additional risk derive benefit from treatment with ventilation tubes. This was statistically tested by comparing two groups of subjects with an additional risk: a group of untreated OME subjects and a group of treated OME ("OME-VT") subjects. The data of this contrast analysis were only considered when the interaction between OME and the additional risk factor proved to be significant.

A secondary hypothesis was that the more risk factors are present, the larger will be the negative effect of OME on the child's performance, with effects ranging from small (when no additional risk factor is present) to substantial (when more than two risk factors coincide). This question was tested by comparing the trend of each effect at three levels of additional risk (0, 1, or more). The language and educational achievement measures of the variables were similarly grouped for the different MAXOVAs as in Griezink et al. (1993) and Peters et al. (1994) (Table I).

Results
In the first part of this section, the effects of OME plus a single risk factor are considered. One-tailed tests were used. In the second part of the section, the effect of a number of risk factors together with OME are considered. The F-test outcomes in this part are given only when results were in the predicted direction and were significant.

COMBINED EFFECT OF A SINGLE RISK FACTOR PLUS OME
As revealed by either a $\chi^2$ test or a t test, there were no significant differences between the OME ($N=151$) and control subjects ($N=82$) with regard to sex ($\chi^2(1, N=233)=3.45, P=0.06$), grade level ($\chi^2(3, N=233)=1.36, P=0.72$), age ($t(231)=0.13, P=0.90$) or intelligence ($t(231)=0.40, P=0.69$).

Educational level of parents
When the data were analyzed with the educational level of the parents as the risk variable, the children of parents with a low educational level constituted the risk group. A low educational level was defined as primary educational level and/or vocational training. The data of some children could not be used because information of the educational level of one or both parents was missing. Of the 151 children in the OME sample, 25 had two parents with a low educational level and 109 had at least one parent with a higher educational level. Of the 37 children with OME who were treated using ventilation tubes, 11 had two parents with a low educational level and 24 did not. Of the 81 subjects without OME, 18 belonged to the high-risk group and 51 belonged to the low-risk group. There were no interaction effects between the educational level of the parents and OME on general language ability, phonological ability, grapheme knowledge, spelling or reading.

There were differences, in the predicted direction, in the educational level of the parents in the non-OME group for general language ability [$F(2,235)=4.52, P<0.01$; univariate effect on Word Forms Production, $F(5,236)=8.35, P<0.01$], for spelling [$F(2,235)=2.28, P=0.05$; univariate effect on real words, $F(5,236)=4.48, P<0.05$, and on pseudowords, $F(5,236)=2.85, P<0.05$] or for word reading (One-Minute test, $F(1,234)=5.17, P<0.05$; Word Recognition, $F(4,187)=1.96, P=0.05$; univariate effect on latency of pseudowords, $F(5,190)=3.90, P<0.05$). No differences were found for phonological ability, grapheme knowledge or sentence verification.

OME apparently had no additional negative effect on language, reading, and spelling ability in subjects of parents with a low educational level. The general language, reading, and spelling abilities of the OME children of parents with a low educational level were relatively poor, but a low educational level of parents did not appear to constitute a risk factor for phonological ability or sentence verification.

SEX
The OME group consisted of 80 boys and 71 girls, the OME-VT group, of 23 boys and 14 girls, and the control groups, of 33 boys and 49 girls. There was no interaction effect of sex and OME for general language ability, phonological ability, grapheme knowledge, or reading. However, there was a multivariate interaction on spelling ($F(2,233)=3.34, P<0.05$; pseudowords, $F(1,264)=5.18, P<0.05$), as can be seen in Figure 1. The estimate of the parameter of the interaction effect was 0.08. Since the root mean square error was 0.24, the effect was 0.08/0.24 = 0.33. This means that the effect was one-third of the within-group variability.

In the non-OME group, there were differences between the boys and the girls for spelling [$F(2,233)=3.63, P<0.05$], but none of the univariate tests proved to be significant. There were no differences in general language ability, phonological ability, grapheme knowledge or reading.

Because an interaction effect between sex and OME for spelling of pseudowords was found, any effect of treatment with ventilation tubes was sought for the boys with OME; none was found.

Early OME appeared to affect the later spelling performance of boys. In the non-OME group, no differences were found between boys and girls with regard to language ability, phonological ability, spelling, or reading. Treatment with
ventilation tubes was not found to affect the spelling performance of the boys with OME.

Non-verbal intelligence
The children were divided into two groups. A risk group, consisting of all the children scoring below the 35th centile on the Raven Coloured Progressive Matrices, was compared with the remaining children. Of the 151 OME subjects, 16 were at risk; of the 37 OME VT subjects, seven were at risk; of the 82 control subjects, 13 were at risk. There was no interaction between intelligence and OME for general language ability, phonological ability, grapheme knowledge, spelling, or reading.

There was an effect of intelligence within the non-OME group on general language ability (F(2,213)=8.41, P<0.001: both univariate tests: Word Forms Production, F(5, 264)=4.34, P<0.05; Constrained Meanings, F(6,264)=16.05, P<0.0001), phonological ability (Phonemic Segmentation and Sound Blending, F(4,261)=1.95, P<0.05: univariate tests for phonemic segmentation: real words, F(1,264)=2.89, P<0.05; pseudowords F(1,264)=6.25, P<0.05), grapheme knowledge (F(1,264)=5.30, P<0.05), spelling (F(2,263)=3.48, P<0.05: both univariate tests: real words, F(1,264)=6.53, P<0.05, pseudowords, F(1,264)=3.32, P<0.05), and reading (One-Minute test, F(1,262)=3.30, P<0.05: Word Recognition, F(4,269)=2.79, P<0.05: univariate tests of percentage correct by word type: real words, F(1,211)=10.01, P<0.01, pseudowords, F(1,211)=3.16, P<0.05). There were no effects on auditory discrimination or sentence verification.

The combination of low non-verbal intelligence and OME did not appear to have a detrimental effect on language, reading, or spelling ability. A low non-verbal intelligence alone appeared to decrease a child's general language ability, phonological segmentation skills, grapheme knowledge, and spelling and reading ability but did not appear to influence auditory discrimination or sentence verification.

Preterm birth and/or low birthweight
Children with a gestational age less than 32 weeks and/or LBW children (birthweight less than 2500g) constituted the risk group in these analyses; this group consisted of 13 of the 138 subjects with OME, 4 of the 37 with OME VT and 2 of the 80 control subjects. There was no interaction of preterm birth and LHW with OME for general language ability, phonological ability, grapheme knowledge, spelling, or sentence verification. However, there was an interaction for reading, but not in the predicted direction (Figs. 2–4).

There was an effect of preterm birth and low birthweight in the control group. Both subjects with the risk factor showed the poorest scores: phonological ability | Auditory Discrimination, like pairs and unlike pairs, both F<1; Phonemic Segmentation and Sound Blending | F(4,240)=3.20, P<0.05: both univariate tests: real words, F(1,240)=11.22, P<0.001, and pseudowords, F(1,240)=11.50, P<0.001; word reading | One-Minute test F(1,247)=4.28, P<0.05: Word Recognition, F(4,194)=8.88, P<0.001: univariate tests: percentage correct of real words, F(1,197)=23.16, P<0.001, and of pseudowords, F(1,197)=5.37, P<0.02, latency of real words, F(1,197)=10.04, P<0.01, and of pseudowords, F(1,197)=5.39, P=0.05. There was no effect on general language ability; grapheme knowledge, spelling, or sentence verification.

There seemed to be no specific effect of OME when it co-occurs with preterm birth and LBW. Preterm and/or LBW children had lower scores than controls for phonological abili-

Figure 2: Mean number of correct answers on One-Minute test for OME and control subjects, according to risk factor gestational age or birthweight. LHW = low birthweight.

Figure 3: Mean percentage of correct answers on Word Recognition test for OME and control subjects, according to type of word (real or pseudo) and to risk variable (gestational age and birthweight).

Figure 4: Mean latency of correct answers on Word Recognition test for OME and control subjects, according to type of word (real or pseudo) and to risk variable (gestational age and birthweight).
ty, spelling, and word reading. They did not differ from the controls in general language ability, auditory discrimination, grapheme knowledge, or sentence verification. However, both of the subjects in the risk group without a history of OME produced markedly poorer results than the other subjects.

Additional analyses
Preterm and LBW children nevertheless form a special risk group because they seem to be very susceptible to OME (Pearce et al. 1988, Engel et al. 1996). Because of the high number of preterm and LBW children with a history of OME in our study, only two children could be found with this risk but without a history of OME; this group was compared with control children without this risk or a history of OME in an additional analysis.

There were no significant differences between the preterm and LBW subjects with a history of OME and the control subjects in general language ability, auditory discrimination, reading of real words and sentence verification. However, there were significant differences in phonological ability (Phonemic Segmentation and Sound Blending, [F(4,246)=2.63, P=0.05; univariate tests of phoneme segmentation: real words, [F(5,240)=8.58, P<0.01, and pseudowords, [F(5, 240)=3.61, P=0.05; univariate test of sound blending: real words, [F(5, 240)=5.22, P<0.03], grapheme knowledge [F(1,249), P<0.01], spelling [F(2,248)=2.38, P<0.05; univariate tests: real words, [F(5, 240)=4.73, P<0.05, and pseudowords [F(5, 240)=4.00, P<0.05], and word reading [Word Recognition, [F(4,194)=2.06, P<0.05; univariate tests of percentage correct: real words, [F(5, 197)=3.06, P<0.05, and pseudowords, [F(5, 197)=5.15, P<0.05]). Furthermore, the non-verbal intelligence levels of these subjects also appeared to be significantly lower than those of the controls [F(1,249)=4.36, P=0.05].

Preterm and LBW children had lower scores than the controls for non-verbal intelligence, phonological ability, grapheme knowledge, spelling, and word reading but not for general language, auditory discrimination, or sentence verification.

First language
There were 35 L2 subjects (children whose first language was other than Dutch), and 270 L1 subjects (children with Dutch as a first language). The distribution among the L2 subjects was: 14 OME subjects, 1 OME-VT subject, and 20 control subjects. No differences were found between the L1 subjects and the L2 subjects in age ([F(267)=1.51, P=0.13], sex (X^2 (1, N=267)=0.08, P=0.42) or year at school ([X^2 (3, N=267)=2.81, P=0.42). There was a difference in the intelligence levels for the two groups ([F(267)=3.78, P<0.001). The L2 subjects had lower non-verbal intelligence scores than L1 subjects. The educational levels of the parents were not useful because in the L2 group there was no information for 29 of the 34 mothers and 31 of the 34 fathers. There were no interaction effects for first language and OME on general language ability, phonological ability, grapheme knowledge or reading. There was an interaction effect on reading, not in the predicted direction (Figs. 5, 6).

An effect of having a language other than Dutch as a first language was observed for general language ability ([F(2,298)=75.16, P<0.0001; both univariate tests: Word Forms Production, [F(5,299)=141.08, P<0.0001, and Conceived Meanings, [F(5,299)=8.07, P<0.01], spelling ([F(2,295)=2.65, P<0.05; both univariate tests: real words, [F(5,296)=3.95, P<0.05, and pseudowords, [F(5, 296)=5.31, P<0.05], and reading [Word Recognition, [F(4,239)=2.20, P=0.05; univariate effect on percentage correct of real words, [F(1,240)=6.11, P<0.05; Sentence Verification, [F(4,260)=2.56, P<0.05; univariate effect on percentage correct of correct sentences, [F(4,267)=6.47, P<0.05]. There were no effects of this variable on phonological ability, grapheme knowledge, or reading. The results suggest that having a language other than Dutch as a first language constitutes a risk factor for language, spelling and reading ability. Combined with a history of OME, however, the problems do not become worse.

Interaction between OME and the number of risk factors
If OME is and of itself is not enough to affect language and literacy negatively but might do so in combination with other risk factors, the effect of OME should become larger with an increasing number of risk factors. To consider this issue, trend analyses were performed with the following risk variables: educational level of both parents, sex, gestational age, and birthweight, and non-verbal intelligence. The variable 'number of risk factors' was added and consisted of three levels: no risk factor, one risk factor, or two or more risk factors.

There were no interaction effects for the number of risk fac-

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**Figure 5:** Mean percentage of correctly spelled real words for OME and control subjects, according to subjects' first language (Dutch or non-Dutch).

**Figure 6:** Mean percentage of correctly spelled pseudowords for OME and control subjects, according to subjects' first language (Dutch or non-Dutch).
The results of the present study indicate that the combined effect of early bilateral OM and other risk factors is only small.

First, the interaction of OM with one additional risk factor was investigated. The results showed OM to produce no effects in combination with the following single risk factors: low educational level of parents, low non-verbal intelligence, preterm birth and/or LBW, and another language than Dutch as a first language. Only one of the predicted interaction effects was found: namely, boys with a history of OM showed a lower spelling ability than boys without a history of OM; there was no such difference for girls. Treatment with ventilation tubes produced no differences.

Second, the possibility that more risk factors would produce a larger effect of OM on language, reading, and spelling performance was investigated. Although a negative linear relation between the number of risk factors and the language, reading, and spelling scores was found (suggesting that the risk factors indeed affect primary and secondary language skills), the results did not confirm the hypothesis of an incremental effect of OM in combination with an increased number of risk factors.

In contrast to suggestions in the literature about possible interactions of OM with risk factors (Bishop and Edmundson 1980, Roberts and Schurle 1990), the present large-scale longitudinal study did not find such interactions. The current study avoided a number of the shortcomings found in previous studies. This study included a large number of children, who were not selected, because a birth cohort was used. The age range of the children was limited. The OM history of the children were systematically documented using tympanometry, which is a reliable way of measuring OM (Zielhuis et al. 1990b). In addition, the present study is the first prospective study to explicitly analyze the relation between OM and several other risk factors (i.e., one risk factor versus an increasing number of risk factors). Comparisons with other studies are difficult, because in most of the recent prospective studies the relation between OM and the risk variables was not studied explicitly. An exception is a handful of studies on the detrimental effects of preterm birth and low birthweight in combination with OM. When risk factors have been included, the ages of the children under study have differed widely, and mostly children in the preschool age have been studied. These differences in the assessment for OM might also account for differences between the present study and others, for example, that of Teelken et al. (1990). Our subjects were all at least 2 years of age. It has been suggested that OM is particularly detrimental if it occurs in the first year of life.

In the present study, a significant interaction between OM and sex was found for spelling. Boys with OM performed particularly poorly in spelling. No interaction effects were found for OM and sex on language or reading ability, a finding which is in accord with that of Roberts et al. (1994).

Our finding that there was no interaction between OM and parental background is supported by the results of a few previous prospective studies. Teelken et al. (1990) found no significant interactions between socioeconomic status of subjects and OM when later cognitive abilities were considered. Roberts et al. (1991) studied the later language performance of children between 4 and 6 years of age from families with lower or middle socioeconomic status (SES). These authors specifically investi-
gated the roles of SES and OME but found only minimal differences. In a later study, Roberts et al. (1994) found no associations between OME groups from birth to 8 years of age and their intellectual development and academic performance at age 8, although their sample was rather restricted and was based on economically disadvantaged children.

No interactions between OME and preterm birth or LBW were found in this study. This is in accord with the findings of Gravel and Wallace (1992). In our study, a remarkably high proportion of preterm and LBW children with a history of OME was found (17/19). Zielhuis et al. (1989a) concluded on the basis of the first part of the Nijmegen Otitis Media study that the contribution of birth-related variables to the prediction of OME was low, but they used the internationally accepted definition of preterm birth (gestational age of less than 37 completed weeks). In many studies, as here, the criterion has been a gestational age of less than 32 weeks. Because of the high number of preterm and LBW children with a history of OME and because of the low number of preterm and LBW children without a history of OME (2 subjects), this group was also compared with control subjects without a history of OME. These additional analyses showed that the preterm and LBW children with a history of OME had lower scores on non-verbal intelligence, phonological ability, grapheme knowledge, spelling, and word reading, but not on general language, auditory discrimination, or sentence verification, in comparison with control children without a history of OME. Preterm and LBW children with and without a history of OME can therefore be considered to be particularly at risk for later language and educational problems.

The findings of the Nijmegen Otitis Media Study Group (Peters et al. 1994, and this study) have shown spelling to be particularly sensitive to OME. However, the effect was rather small.

In interpreting the findings of the present study, the question of whether the 'risk factors' really were risk factors must be considered. Neither the fact of being a boy nor having parents with a low educational level was associated with any particular risk, although these factors did appear to affect some aspects of language, reading, and spelling, which may also explain, at least partially, the lack of interactions.

The present study suggests that bilateral, longstanding OME between 2 and 4 years of age does not interact with a low parental educational level or low non-verbal intelligence of the child, and does not affect a child's language, reading, or spelling ability at age 7. However, there seemed to be a relation between sex and OME, with boys' spelling influenced negatively by a history of OME. OME in combination with preterm birth and LBW also appeared to put children at risk for later language and educational problems. The effects of OME seem to be frequently overestimated. The results of the present study and earlier studies (Grievink et al. 1989; Peters et al. 1994) show that OME, even when combined with a number of other risk factors, produces only minor effects on later language, reading, and spelling performance.

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