

previous TM retraction, while only 78 patients (4.4%) had no evidence of previous retraction. Moderate or severe TM retractions were observed in the CLE of 871 (48.9%) patients, perforation/retraction in 8.9%, cholesteatoma in 13.3%, and TM perforation in 6.7% of patients. The CLE in 395 patients (22.2%) was found to be normal.

*Conclusion:* A low prevalence of marginal TM perforation (2.52%) was observed. The vast majority of ears with marginal perforation bore evidence of previous TM retraction. In addition, TM retraction or cholesteatoma occurred in 71.1% of the CLEs.

doi:10.1017/S0022215116006769

### ID: IP180

#### Isolated Facial Nerve Anomaly Presenting as Conductive Hearing Loss

Presenting Author: **Vrunda Rotte**

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*Learning Objectives:* Patient's history should always be listened carefully. The otologic surgeon should always be prepared for the unexpected. We should always listen carefully to the patient's history. The otologic surgeon should always be prepared for the unexpected.

*Introduction:* Anatomical anomalies of the facial nerve range from common minor bony dehiscence of the tympanic segment to much rarer abnormalities in the course of the nerve. Normally their only relevance is that they may pose an increased risk of injury during tympanomastoid surgery.

*Method:* We report the case of a 60 year old female who presented to the general ENT clinic with right-sided conductive hearing loss. Eventually a grommet was inserted under LA. The hearing did not improve. She was referred to the senior author for tympanotomy. On the day of surgery the patient was asked again about the history of her symptoms and she admitted that she could not be sure if the hearing in her right ear had ever been normal. A permeal tympanotomy was performed under GA. The ossicular chain was found to be intact and mobile. However, the appearance of the promontory was noted to be unusual. The facial nerve was seen to be dehiscent and passing **both above and below** the stapes (intra-operative photograph). This was confirmed by the use of the nerve stimulator. The operation was abandoned and the patient was subsequently informed of the findings.

*Result:* Post-operative recovery was uncomplicated. Post-operative audiometry showed no change in hearing. Preoperative imaging had not been requested as the diagnosis had not been suspected. However, review of the patient's records showed that the patient has had a previous CT scan of the sinuses. On close review of these images, an anomalous course of the facial nerve could be seen (CT images).

*Conclusion:* A facial nerve bifurcating and encircling the stapes is extremely rare and would never have been suspected as the cause of conductive hearing loss. Very few reports of such an anomaly appear in the literature.

doi:10.1017/S0022215116006770

### ID: IP181

#### Tinnitus due to pulmonary disease

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*Learning Objectives:* Present a case of atypical presentation of middle ear tuberculosis.

*Introduction:* A 47 yo woman, with no medical history, presents to A&E with a tinnitus and blocked left ear for 2 weeks.

On physical examination there is inflammation and whitish exudate on the back wall of the pharynx. Left ear has opaque eardrum with hyperemic annulus.

Nasal endoscopy shows inflamed adenoids with abundant exudate and PTA conductive hearing loss in the left ear. Tympanometry is type B curve in the left ear.

*Evolution:* The patient is given deflazacort, cefuroxime and nasal irrigation but 2 weeks later she reports no improvement.

CT scan is ordered to rule out neoplasm. It shows hyperplasia in the left side of nasopharynx that doesn't capture contrast. Left middle ear cleft is opacified with no signs of osteolysis. The neck scan reveals irregular consolidation in the right upper lobe so a thorax CT is performed. It shows scarring, tree-in-bud pattern in right lung, all suggestive of tuberculosis.

PPD test is positive and so are acid-fast staining and culture of the sputum. The patient is diagnosed with pulmonary tuberculosis and 4-drug regimen is initiated (ethambutol, isoniazid, pyrazinamide, rifampin). A month later (so she is no longer contagious) the patient has an adenoidal biopsy and left myringotomy. There is no effusion in the middle ear. The microbiology (swabs) confirms adenoidal and middle ear tuberculosis.

The patient's otic symptoms resolves but 6 months later she reports tinnitus and blocked left ear. Otoscopy is normal but PTA shows small conductive hearing loss. Wait and see attitude is proposed and the patient agrees. 5 months later the patient is free from pulmonary tuberculosis but her left ear remains blocked. Myringotomy reveals very thick transparent fluid and a grommet is inserted. The microbiology is negative for tuberculosis. The patient's symptoms get better.

If the problem recurs once the grommet falls out should we think about scarring of the Eustachian tube? Would a balloon dilatation of the tube be feasible?

doi:10.1017/S0022215116006782

### ID: IP182

#### A Case Report of Keratosis obturans - often misdiagnosed

Presenting Author: **Chinnala Sai Chaitanya**

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*Learning Objectives:*

A Case Report of Keratosis obturans - often misdiagnosed

*Introduction:* A case report of Keratosis Obturans in a 32 year female patient. The condition is often misdiagnosed and requires careful history taking and clinical examination to diagnose and rule out the disease. It should be differentiated from external auditory canal cholesteatoma, presence of osteonecrosis and focal overlying epithelial loss are the most reliable features favouring the diagnosis of external ear canal cholesteatoma over keratosis obturans

*Materials and Methods:* All the necessary investigations viz. routine Blood investigations, serological profile, imaging studies i.e HRCT Temporal bone both sides along with orthopantomogram to rule out (TM)Temporo-mandibular joint involvement was done, Pure tone Audiometry was done which showed moderate to severe conductive hearing loss on the affected side.

Patient was planned for surgery under GA.

*Result:* While operating large keratotic mass was seen extending superiorly into tegmen, posteriorly into mastoid extending upto tip cells, anteriorly involving TM joint, the entire keratotic mass was removed and bone was drilled, wide canal meatoplasty was done, excised mass was sent for HPR and was confirmed as keratosis obturans, post operative CT scans were done to recheck.

*Conclusion:* Keratosis obturans is a rare disease and often misdiagnosed, proper diagnosis with help of imaging modalities is essential to plan for surgery and eradicate disease.

Trauma and anatomical deformity of TM joint and EAC might be a precipitating factor.

doi:10.1017/S0022215116006794

**ID: IP183**

**A Case of Extensive Cholesteatoma with Bezold's Abscess**

Presenting Author: **Chinnala Sai Chaitanya**

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*Learning Objectives:* A rare case of Extensive cholesteatoma with Bezold's abscess.

*Introduction:* A case of 19 year female patient with complains of continuous foul smelling discharge and swelling behind ear in mastoid region extending to upper neck region came to our OPD. On examination it was diagnosed as attico antral type of COM with Bezold's abscess diagnosis confirmed by CT imaging.

*Materials and Methods:* All the necessary investigations viz. Routine Blood investigations, serological profile, imaging

studies i.e HRCT Face including Temporal bone and neck, Pure tone Audiometry was done which showed severe conductive hearing loss on the affected side. Patient was planned for I and D of abscess further planned for Radical mastoidectomy under GA.

*Result:* Following I & D we saw large amounts pus draining from abscess and erosion of cortical bone with huge extensive cholesteatoma debris, hence planned for mastoidectomy extending the incision further planned for radical mastoidectomy, we saw huge extensive cholesteatoma filled in mastoid cavity with multiple fistulae was noted, steps of radical mastoidectomy followed, adequate post op care was taken.

*Conclusion:* Cholesteatoma has been known to be associated with multiple complications either extracranially or intracranially. Among the extracranial complications, mastoiditis and mastoid abscess are the most common. Bezold's abscess formation with cholesteatoma is a rare occurrence but when present can lead to sinister sequelae if not properly managed. The treatment of cholesteatoma is mainly by surgical exploration namely mastoidectomy. The aim of treatment is to eradicate the diseased mastoid and to prevent subsequent complications. Beside surgical intervention, the patient will also require intensive systemic and topical antibiotic therapy. With proper treatment patient will be rescued from experiencing further life-threatening complications.

doi:10.1017/S0022215116006800

**ID: IP184**

**Use of a thinly sliced cartilage technique in a canal wall up procedures**

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*Learning Objectives:* We have performed canal-wall-down tympanoplasty reconstruction with soft posterior meatal wall for cholesteatoma as a single-stage operation from 1998 to 2009. Although this method designed to prevent a cholesteatoma recurrence, posterior meatal wall often retracts like balloon similar to that of conventional open method operation and it has sometimes caused cavity problems, in long-term follow-up.

As you know, in approximately 80% of an anterior attic bony plate of pars flaccida is closed in cholesteatoma cases. As results ventilation routes from Eustachian tube to epitympanum and mastoid antrum are hard to be formed by the single staged operation.

Therefore, after 2010, we decided to perform thinly sliced cartilage technique in a canal-wall-up procedure with planned staged tympanoplasty in many cases.

Cartilage is used as perichondrium-cartilage island flap, and it includes treatment and prevention of attic retraction, reconstruction of scutum and reconstruction of tympanic membrane. This cartilage is the size enough to reconstruct scutum and an eardrum by one. The island flap is simple to use more than a way using both of a cartilage and a