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.

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ID: IP180

Isolated Facial Nerve Anomaly Presenting as Conductive Hearing Loss

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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 regular 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 subsequently informed of the findings.

Conclusion: A facial nerve bifurcating and encircling 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.

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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 opacificated with no signs of osteolysis. The neck scan reveals irregular consolidation in the right upper lobe so a torax 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 see attitude is proposed and the patient agrees. 5 moths 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 (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 moths 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?

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ID: IP182

A Case Report of Keratosis obturans - often misdiagnosed

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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 orthopantogram 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.

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 flacida 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