

graft status and pure tone audiometry were performed for all the patients and the outcomes were compared.

**Results** Out of 35 patients in each group, four in the study group and eight in the control group had residual perforation. Graft uptake in case group was 88.57% and graft uptake in the control group was 77.1%. Result was better in cases that underwent myringoplasty with PRP. Out of 35 patients in case group, audiological improvement ( $> 10$  dB) was seen in 31 patients (88.57%); in the control group of 35 patients, 27 (77.1%) had audiological benefits.

**Conclusion** This study shows there is definite benefit by using PRP in myringoplasty. As the PRP can be easily prepared, PRP myringoplasty can be routinely performed.

#### **A0043: Management of Recurrent Collaural Fistula: A Case Report**

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**Introduction** Collaural fistula or cervicoaural fistula is a rare anomaly accounting for less than 8% of first branchial cleft anomaly. Aberrant development of first branchial cleft may lead to formation of a cervical cyst or sinus in the region of ear.

**Case Report** We reported a case of a 4-year-old girl who presented with recurrent swelling in right infra-auricular region from 6 months of age. She had undergone incision and drainage of the swelling thrice at various peripheral hospitals over past 3.5 years. On examination, two sinuses were noticed surrounding lobule of right pinna of which one was present posterior to the lobule and second was present just above lobule at lateral most part of conchal cartilage.

**Discussion** Diagnosis of recurrent infected collaural fistula requires detailed clinical examination for presence of multiple sinuses surrounding the lobule and external auditory canal. In case of nonvisibility of sinus in external auditory canal, microscopic examination should be done. CT sonogram and MRI are useful diagnostic tools for recurrent infected fistulas. Surgical excision of whole tract is the definitive treatment but superficial parotidectomy along with it can reduce chances of recurrence significantly. If more than 30% of the circumference of external auditory canal is involved then split skin grafting is required for the coverage.

**Conclusion** Diagnosis of collaural fistula should be kept in mind whenever there is recurrent postaural or infra-aural swelling mainly in pediatric patients. Superficial parotidectomy along with complete excision reduces the recurrence rate. Facial nerve palsy can be a devastating complication of surgery.

#### **A0044: Case Report: Delayed Facial Nerve Paralysis—An Uncommon Complication of Tympanomastoid Surgery**

Spandana. S. Pardikar

**Introduction** Facial nerve paralysis after ear surgery is a troublesome postoperative complication for both patient and the surgeon. Delayed postoperative facial nerve paralysis (DPOFNP) occurs a few days after ear surgery. The cause for this condition is supposed to be reactivation of dormant herpes zoster virus present in geniculate ganglion.

**Case Presentation** We, hereby, present a case of 25-year-old male, a case of chronic suppurative otitis media atticoantral disease who underwent canal wall down mastoidectomy with tympanoplasty. He presented with complaints of facial nerve paralysis, 7 days after the surgery. Patient had a House–Brackmann grade-3 paralysis. Treatment was initiated with oral corticosteroids and oral acyclovir. Patient was recovered completely after the therapy.

**Discussion** DPOFNP is an uncommon complication following uneventful tympanomastoid surgery. It is due to mechanical reactivation of HSV-1 virus in geniculate ganglion following mechanical disturbance of chorda tympani or operating in close vicinity to the facial nerve. It can also occur following neuro-otological surgery like acoustic neuroma and vestibular neurectomy, following stapedectomy or cochlear implantation.

**Conclusion** Patient presenting with facial nerve paralysis a few days after uneventful tympanomastoid surgery should be diagnosed as DPOFNP. The patient should be reassured and given a course of oral corticosteroids and acyclovir. Overall prognosis is good.

#### **A0045: Ancient Schwannoma Mimicking Glomus Jugulare**

Sreenivas Kamath K.

**Introduction** Schwannomas are benign tumors arising from the nerve sheath. Schwannoma of the jugular foramen (JF) is rare. We report a case of ancient schwannoma arising from the JF, the first of its kind to be reported in the literature.

**Case Report** A 37-year-old male presented with ear pain, pulsatile tinnitus, reduced hearing in the left side since 6 months and ear discharge since 3 months. Past history of ear surgery was done for ear discharge 15 years back. No history of difficulty in speech and swallowing, nasal regurgitation, facial deviation, hemifacial spasms, or dizziness was reported.

On examination: left EAC—reddish polyp was present, did not bleed or pain on touch. Post aurial scar was present. Right ear: normal. Audiological testing was suggestive of moderate conductive hearing loss on left and minimal hearing loss on right. There were no obvious neurological deficits on examination.

Investigations: HRCT showed skull base isodense lesion with extension into jugular foramen—glomus jugulare (GJ). Contrast MRI well defined extra-axial, soft tissue enhancing mass in relation to the left CP angle involving petrous part of temporal bone with extension into the middle ear and external ear with salt and pepper appearance—GJ/ Nerve sheath tumor. MRA showed encasement of the ICA by the lesion with no obvious feeders.

Treatment: patient underwent left side transmastoid transtemporal excision of the tumor. Intraoperatively ECV and IJV were ligated. Facial nerve was identified and transposed. Tumor mass completely removed in peacemeal, reconfirmed with endoscopic evaluation. Defect was sealed using abdominal fat graft. Postoperative grade-4 facial palsy noted. HPE: spindle cells arranged in sheets having elongated nuclei

with hypocellular areas and nuclear atypia—s/o ancient schwannoma.

**Discussion** JF mass can be classified according to the structure of origin; it was to be extrinsic or intrinsic. Based on history and imaging characteristics, the diagnosis was thought to be GJ. But histopathological diagnosis was AS. There are four variants of schwannoma. AS is characterized by degenerative changes, such as hemorrhage, cystic degeneration, hyalinization and calcification. These characteristics mimic GJ on imaging giving salt and pepper appearance. Treatment is surgical excision since it is a benign tumor and radioresistant with good prognosis.

**Conclusion** Schwannomas of JF though rare has to be considered as a differential diagnosis for JF mass; however, the treatment remains the same with good prognosis.

#### A0046: Facial Nerve Decompression

Sweta Mary

In case of trauma or accidents, patients can have temporal bone fracture resulting in facial nerve palsy. Temporal bone fractures, blunt or penetrating head and neck trauma, and iatrogenic surgical injury are all common causes for facial nerve injury. Immediate paralysis is suggestive of nerve disruption or severe compression, such as bone fragment. Temporal bone fractures are classified as longitudinal or transverse or mixed. It is described as nerve swelling within the bony canal. The edema and inability to expand beyond the bony confines creates a conduction block which prevents the axoplasmic flow. In case of temporal bone fracture, the treatment for facial nerve palsy depends on the fracture location and the ideal time for surgery following trauma. In our OPD, a patient came with alleged history of trauma following which he had facial nerve palsy. We performed facial nerve decompression and patient had a good prognosis, postoperatively. Facial nerve decompression is a surgery recommended for complete facial nerve palsy in which patients get benefitted by regaining the facial nerve functions. Surgical decompression of all nerve segments affected by temporal bone fracture should be performed using middle cranial fossa approach or transmastoidal approach or translabyrinthine approach.

#### A0047: Association of Central Obesity with the Severity and Audiometric Configurations of Age-Related Hearing Impairment

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**Aim** 1. To know the relationship between central obesity with age-related hearing loss.

2. To know the most important indicator of central obesity associated with age-related hearing loss.

3. To know the relationship if any between age, degree of obesity, and configuration of hearing loss.

4. To know the relationship between diabetes mellitus, hypertension with the central obesity, and severity of hearing loss.

**Material and Methods** This is a prospective, randomized, single blind study performed over a period of

2 years from August 2016 to July 2018. Six hundred patients who attended outpatient department (OPD) in the Department of Otorhinolaryngology, with sensorineural hearing loss following inclusion criteria, are included in the study. Detailed history was taken followed by clinical examination. All patients were subjected to complete ENT examination, pure tone audiometric examination was done in all cases (MAICO MA42 audiometer). Height, body weight, and waist circumference (WC) were measured.

**Results** The correlation between obesity and SNHL was found to be more significant in females than males. Obese and diabetic patients of both sexes were found to have higher degree of hearing loss for both high and low frequencies as compared with nonobese patients. Good correlation was found between BMI and degree of hearing loss. Abrupt high tone loss type of audiometric configuration was the commonest finding in both male and females.

**Conclusion** There is a correlation between ages related to sensory neural hearing loss with central obesity and its comorbidities, with waist circumference as the most important indicator.

**Clinical Significance** A careful understanding of the modifiable risk factors for age-related sensory neural hearing loss help in its early detection and prevention.

#### A0048: The Depth of Facial Nerve in the Mastoid Bone

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**Background** The hallmark of the temporal bone is variation. Various important structures like the facial nerve run in the temporal bone at various depths can be injured during mastoidectomy.

**Method** Twenty wet cadaveric temporal bone were dissected. A cortical mastoidectomy was performed followed by a canal wall down mastoidectomy and the depth of the vertical segment of the facial nerve in the mastoid was determined.

**Results** The mean depth of the second genu was 13.8 mm. The mean depth of the stylomastoid foramen was 12.75 mm and the mean distance from the annulus at 6'o clock to the stylomastoid foramen was 10.22 mm.

**Conclusion** There is significant variation in the average depth of the facial nerve in the mastoid.

#### A0049: Comparative Study between Microscopic Myringoplasty and Endoscopic Myringoplasty

**Aim** To compare the outcomes of microscope-assisted postauricular approach tympanoplasty using temporalis fascia and endoscope-assisted endomeatal tympanoplasty using tragal perichondrium, among patients with CSOM.

**Materials and Methods** In 81 patients, group A consisted of 40 patients who underwent endoscopic myringoplasty and group B consisted of 41 patients who underwent the conventional microscopic technique, the outcome was analyzed in terms of the hearing gain, duration of surgery, graft success rate, and to study the comparative benefits of endoscopic tympanoplasty over microscopic tympanoplasty