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Learning Objectives: A high jugular bulb is a common vascular anomaly and the possibility of dehiscence should always be anticipated when pre-operative imaging is not available. If it is accidentally damaged and bleeding occurs, the ear should be packed and the procedure abandoned.

Introduction: Anatomic variations of the venous sinuses of the dura mater, however infrequent, may present puzzling diagnostic and operative problems. A high dehiscent jugular bulb is one of the most common and if not anticipated can present a hazard when performing middle ear surgery.

Method: We report the case a 10 year old girl with bilateral dry central tympanic membrane perforations who was admitted for right tympanoplasty. Through a post-aural approach temporalis fascia was harvested and the edges of the perforation freshened. A tympano-meatal flap was raised and as the annulus was lifted a sudden gush of blood ensued. A dehiscent jugular bulb was recognised. Instead of simply packing the ear and abandoning the procedure a decision was made to explore the mastoid in an attempt to control bleeding by compressing the sigmoid sinus so that the procedure could be completed. This greatly worsened the problem as the sigmoid sinus was huge, dehiscent and totally filling the mastoid. This started to bleed even more profusely. Telephone advice was sought from an eminent skull base surgeon who warned that an attempt to occlude the sigmoid sinus could compromise cerebral venous drainage if the contralateral sinus was vestigial. He advised the use of Floseal, Sugicel, crushed temporalis muscle and bone wax. Haemostasis was rapidly achieved and the tympanoplasty completed.

Result: Post-operative recovery was uneventful. Successful cloure of the perforation and improved hearing was achieved. Subsequent CT scanning showed good venous flow bilaterally (images).

Conclusion: A high jugular bulb is a common vascular anomaly and the possibility of dehiscence should always be considered when pre-operative imaging is not available. The decision to open the mastoid instead of simply packing the ear canal and abandoning the procedure was misguided and could easily have resulted in serious complications. It should not have been considered in the absence of pre-operative imaging.

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ID: IP045

The Role of Surgery in the Management of Malignant (Necrotising) Otitis Externa

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Learning Objectives: To highlight the role of surgery in the management of malignant (necrotising) otitis externa.

Introduction: Malignant (Necrotising) Otitis Externa (MOE) was first described in 1959 as a pseudomonal osteomyelitis of the temporal bone in an elderly diabetic. Subsequent single case reports appeared in the literature. It was said to be an extremely rare condition. Although a number of early publications reported surgical intervention, the prognosis was very poor and the mortality high. By the time the senior author was in training, the standard teaching was that surgery had no role to play in the management of MOE.

Over the past 20 years our experience has been that the incidence of MOE has increased dramatically. The role of fungul infection in conjuction with pseudomonas may make successful treatment more difficult.

In a small but significant number of our patients surgery has been used as an adjunct to medical therapy.

Methods: We report a series of 4 patients with MOE who all had tympanomastoid surgery as part of their treatment. All had had uncontrolled pain and In two cases facial palsy was an indication. In one the palsy had been present for over three months.

Results: Following surgery all four patients had significant and rapid control of their pain. The two patients who had had facial palsies both recovered, one completely and rapidly and the other to a House-Brackmann grade II after 9 months.

Conclusions: We are seeing far more patients with MOE than ever before. We postulate why this might be.

While aggressive medical therapy is vital, surgery should be considered in the management of patients with MOE when the symptoms and clinical signs are progressing despite adequate medical treatment. Facial palsy should be considered as an indication for early surgery in MOE just as it would be in other inflammatory diseases of the temporal bone.

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ID: IP046

Transmastoid middle fossa craniectomy for the supralabyrinthine lesion

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Learning Objectives:

Introduction: For a petrous apex lesion with serviceable hearing, the middle fossa (MF) craniotomy combined with transmastoid approach (TMA) is usually selected to preserve the labyrinth. However, this combination seems too invasive if the pathology is localized rather laterally. We have made a technical modification on TMA so that we can access a supralabyrinthine lesion more easily with an addition of partial MF craniectomy.