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"Phone a friend" - three challenging cases, one invaluable friend

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Learning Objectives: Developing a close relationship with a senior colleague who is readily accessible in an emergency early in one's career can pay huge dividends.

Introduction: No matter how long a surgeon has been in practice, from time to time they will inevitably find themselves in an unexpected situation where they are in difficulty and out of their depth. At such times it is vital to know where to turn for help.

Method: We describe three cases over a 20 year period which illustrate the value of having such a friend and colleague to turn to.

Case 1: a 60 year old female who had undergone a modified radical mastoidectomy over 20 years previously. She had had several episodes of facial palsy associated with an infected mastoid cavity which had resolved after microsuction under GA. On this occasion a complete palsy persisted for 3 weeks despite microsuction and a decision was made to explore the ear. The nerve was found to be dehiscent and attenuated to less than a quarter of its normal calibre at the second genu. Telephone advice was to excise the damaged segment, mobilise, reroute and perform primary end to end anastomosis.

Case 2: a 50 year old female presented with a persistent ear discharge after grommet insertion for a middle ear effusion. CT imaging suggested chronic mastoiditis, however, upon exploration a dehiscent tegmen and middle fossa dura was found with herniated temporal lobe and profuse CSF leakage. Telephone advice was to resect the herniated brain, repair the dura with fascia, crushed muscle and Surgicel before obliterating the mastoid.

Case 3: a 10 year old girl undergoing tympanoplasty had life-threatening bleeding from a dehiscent and massively dilated sigmoid sinus. Telephone advice was to repair the leak with fascia, crushed muscle, Floseal, Surgicel and bone wax.

Results: The first patient recovered facial nerve function to HB grade 2–3. The second and third patients had uneventful and complete recoveries without the need for further surgery.

Conclusion: Contacting an experienced colleague by telephone from the operating theatre can often save the day.

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Ten years after the 7/7 bombings - an otologic perspective

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Learning Objectives: Physical injuries suffered by victims of terrorism may be identical to those caused by accident. However, the psychological Impact of terrorism may worsen the prognosis for fully recovery. It is important that victims of terrorism receive the most expert assistance at the earliest possible stage if they are to have the best chance of complete recovery from their physical injuries.

Introduction: The London bombings of 7th July 2005 left 56 dead (including the perpetrators) and over 700 injured. Ear damage is extremely common following exposure to explosions. Those injuries include tympanic membrane rupture, which may or may not heal spontaneously, sensorineural hearing loss, tinnitus, and vestibulopathy. The prognosis is variable and may be influenced by many factors.

Method: We present three patients treated in our institution who each suffered ear damage during the 7/7 bombings.

Case 1: a 19 year old autistic man sustained a ruptured left tympanic membrane and when initially seen had an actively discharging middle ear. Microsuction was performed and topical antibiotic drops prescribed.
Case 2: a 60 year old civil servant sustained a central tympanic membrane perforation with associated mixed hearing loss and tinnitus. After this failed to heal tympanoplasty was performed.
Case 3: a 21 year old lady sustained bilateral tympanic membrane perforations which failed to heal. She underwent surgery on both ears including revision on the first side.

Results: The first patient's tympanic membrane healed spontaneously but he represented several times with otitis externa in the previously damaged ear. The second patient's surgery was successful in closing the perforation but he is left with persistent tinnitus and is now using hearing aid. The third patient had and iatrogenic middle ear cholesteatoma following her first operation resulting in ossicular erosion. After revision surgery and repair of the contra lateral perforation she had been left with mild bilateral hearing loss. 10 years on she has tinnitus which at times is disabling, recurrent BPPV and chronic imbalance.

Conclusion: Blast injury to the ear can result in a spectrum of injuries which may or may not leave lasting disability. The psychological trauma inflicted on victims of terrorism can have a significant impact on their ability to cope with tinnitus and vestibular symptoms.

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Life Threatening Bleeding during Tympanoplasty in a Child

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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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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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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.