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, perforationretraction 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 permeatal 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(intraoperative 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 inflammated 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 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 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?

doi:10.1017/S0022215116006782

## ID: IP182

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

Presenting Author: **Chinnala Sai Chaitanya**