ABSTRACT

A 45-year-old female presented with bilateral chronic suppurative otitis media since 1 year and right facial paralysis (House-Brackmann grade IV) since 4 days. Examination showed a conductive hearing loss and CT scan showed soft tissue opacity in the right middle ear cavity with probable erosion of the tympanic segment of fallopian canal. Modified radical mastoidectomy (canal wall down type) with complete removal of granulation tissue from the middle ear, anterior and posterior epitympanum, aditus and mastoid antrum was performed. There was no evidence of cholesteatoma. The patient had high surgical gain and a marked improvement in facial nerve function (House Grade I) one month postoperatively was seen. The present case highlights the need of early surgery for decompression of facial nerve to prevent irreversible damage.

Case report

A 45-year-old female presented with facial asymmetry of 4 days duration along with h/o discharge from both ears (off and on) since the past one year. Examination of both ears revealed small central perforation and scanty mucopurulent discharge. It was associated with hearing loss. Tuning fork test showed bilateral conductive hearing loss (PTA: right ear 50dB, left ear 20dB). Examination of face revealed a lower motor neuron type of facial paralysis (House-Brackmann grade IV) involving the right side. CT scan of the temporal bone revealed soft tissue opacity in the right middle ear cavity with suspicious erosion of lateral wall of tympanic segment of right facial nerve canal. The neutrophil count was found to be 80%. The other parameters were within normal limits.

The patient was put on conservative treatment with intravenous ceftriaxone (1g BD), oral steroids (prednisolone 1 mg/kg body weight in 3 divided doses) and oral acyclovir (200mg 5 times a day). Patient was followed up for 5 days during which there was no improvement in the degree of facial nerve paralysis.

The patient was subjected to mastoid exploration under general anaesthesia. Modified radical mastoidectomy (MRM; canal wall down type) was done. There was presence of florid granulation tissue in the middle ear, attic, aditus and antrum; however no evidence of cholesteatoma was seen under the operating microscope. The granulation tissue was pale in appearance. Examination of the ossicles revealed erosion of the long process of incus along with partial erosion of the head of erasers with discontinuity of the incudostapedial (IS) joint. Granulation tissue was removed completely; there was no dehiscence of facial canal. Facial nerve decompression was done without epineural incision in the tympanic segment. Diseased ossicles were removed and incus was reshaped and placed over the stapes head. The atelectatic drum was removed, which resulted in a subtotal perforation. Conchal cartilage was harvested and placed in the middle ear in palisades and temporalis facia graft was placed.

There was marked improvement in the facial nerve paralysis (House grade I) in the immediate postoperative period. The patient was followed up after one month and showed complete recovery of the facial nerve functions (House grade I).
gent surgery in the management of chronic suppurative otitis media when facial nerve paralysis supervenes.