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# ROLE OF ENDOSCOPIC ASSESSMENT OF EXTENT OF CHOLESTETOMA DISEASE IN MIDDLE EAR CLEFT

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KEYWORDS

## INTRODUCTION:

Chronic otitis media is a major health problem in many indigenous population around the world. Cholesteatoma disease is a very common disease found in day to day ENT OPD it is dangerous because of its potential intracranial or intracranial complications.

Conventionally microscopic modified radical mastoidectomy is used for attic – antral disease and proved to be effective tool in eradicating cholesteatoma from middle ear cleft. Most surgical failures associated with mastoidectomy seem to occur because of residual disease. Residual diseases are mostly found in hidden areas of temporal bone. These areas cannot be assessed by operating microscope. Angled endoscope may help in looking around the corner in the middle ear cleft thus assisting in complete disease eradication.

## AIM:

1. To evaluate the role of middle ear cleft endoscopy in effective control of cholesteatoma through visualizing hidden areas.
2. To assess the extent and presence of chloesteatoma in retraction pocket and to prevent unwanted canal wall down mastoidectomy.

## MATERIAL AND METHODS:

The current work represents single institutional observational prospective study. This study was conducted for period of 1st August 2014 to February 2016 i.e.one and half year in ENT OPD, Audiology Department and Operation Theatre of Dr. Hedgewar Rugnalaya. 100 patients with chronic otitis media active or inactive squamous were included. Patients underwent microscopic canal wall down mastoidectomy and after that intraoperative angled endoscopic assessment of hidden areas was done.

## RESULTS:

In our study attic perforation with cholesteatoma cases were most common 84% and 16 % were retraction pocket where founds was not seen.

In our study 84% cases of activity squamous COM patient underwent routine microscopic clearances by canal wall down mastoidectomy and followed be endoscopic examination shown that in 14% cases we saw residual disease in different hidden areas. In that most commonly residual disease found in facial recess 7% and sinus tympani 7% cases. In retraction pocket cases where fundus was not seen and in limited attic cholesteatoma cases pre operative endoscopy was done to see extent of retraction pocket and 17 % cases limited atticotomy was done.

## CONCLUSION:

After our study we have concluded that Endoscope is a good adjunct tool with microscope in cholesteatoma surgery. We can effectively eradicate cholesteatoma from hidden areas and can reduces the incidence of residual cholesteatomas and it also helpful to decrease the requirement of the second look surgery.

With endoscope we can avoid large cavities in retraction pockets by knowing the extent of retraction pockets. Though endoscope is not a replacement of standard microscopic technique due to less magnification. Depth perception and fogging. Also difficulty in instrumentation because it engages one hand of surgeon.

## Recommendations:

1. All patients who are undergoing for mastoidectomy should undergo endoscopic examination after microscopic clearance.
2. All patient of retraction pockets where we are not able to see fundus should undergo preoperative endoscopy.