

CHRONIC SUPPURATIVE OTITIS MEDIA



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SURGERY
GMCH-32, CHANDIGARH

CHRONIC SUPPURATIVE OTITIS MEDIA

CSOM is a long standing infection of a part or whole of the middle ear cleft, characterized by *ear discharge* and a *permanent perforation*.

(A perforation becomes permanent when its edges are covered by squamous epithelium)



EPIDEMIOLOGY

Incidence is very high in India.

5% of total population at a time has discharging ear.

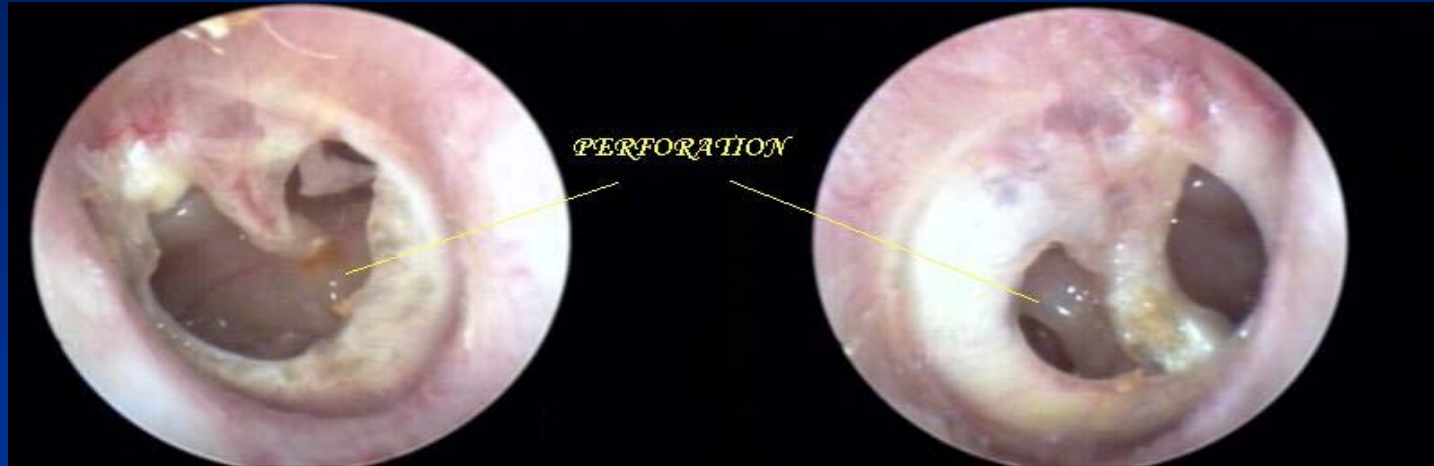
Poor population – increased incidence.

Most common cause of preventable deafness.



TYPES OF CSOM

Tubotympanic (Safe)



Atticoantral (Unsafe)

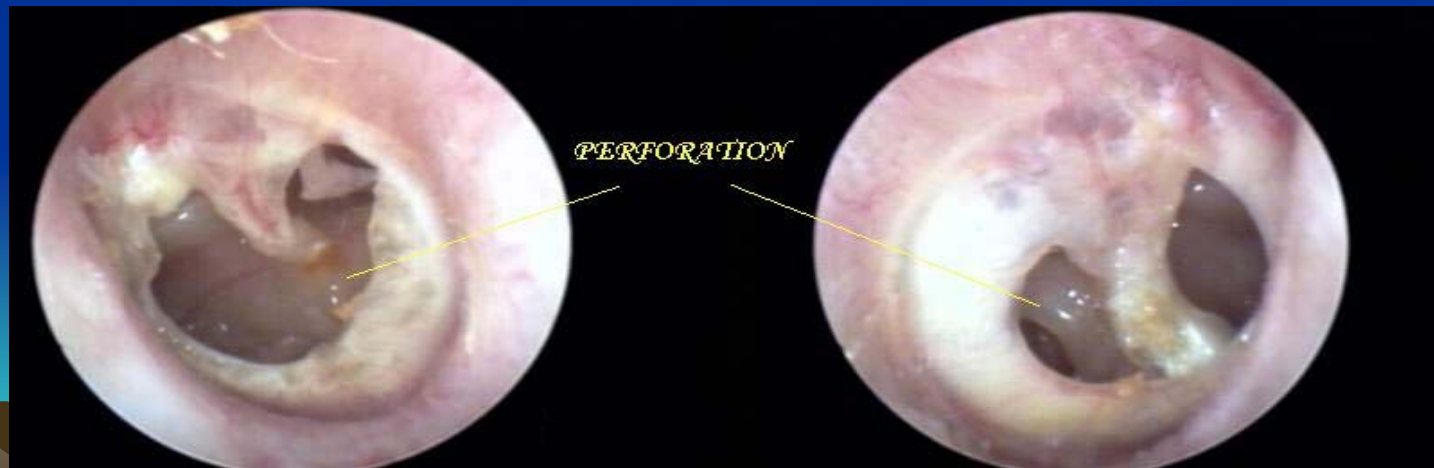


Tubotympanic (Safe)

Disease is confined to mucosa of middle ear.

Central perforation.

Usually no risk of complication.



Atticoantral (Unsafe)

Associated with *cholesteatoma* or granulations causing bone erosion.

Attic or marginal perforation.

Risk of complication is high.



CLINICAL FEATURES

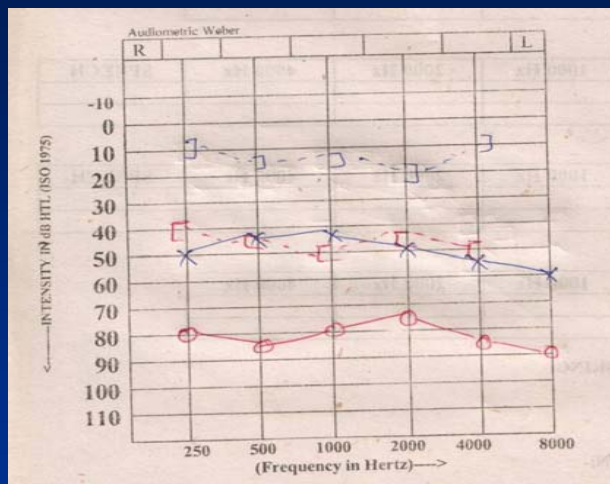
TUBO TYMPANIC

- Ear Discharge – Non offensive Profuse, Mucoid or mucopurulent.
- Hearing loss usually conductive And mild to moderate
- Perforation – always central
- Retraction pocket or cholesteatoma is not present.
- Bacteriology – Gram +ve cocci usually
- Complications – rare

ATTICO ANTRAL

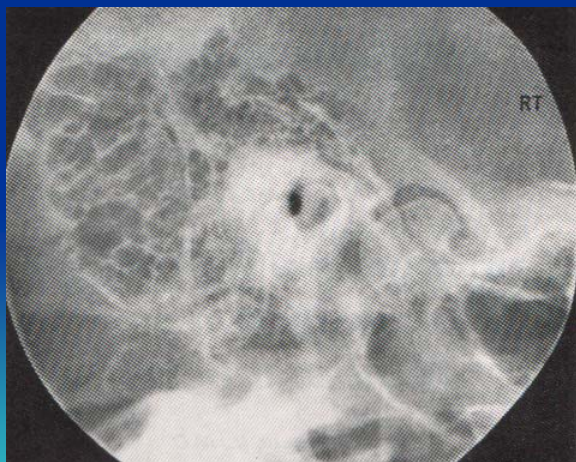
- Scanty, purulent, foul smelling
- Moderate to severe, mixed also
- Attic perforation or marginal perforation.
- Retraction pocket or cholesteatoma is usually seen.
- Pseudomonas, Proteus, E-Coli Staph aureus Anaerobes
- Common

INVESTIGATIONS



- **PURE TONE
AUDIOMETRY**

- **CULTURE
SENSITIVITY**



- **X RAY MASTOIDS**

TREATMENT



TUBOTYMPANIC TYPE

- Aural Toilet
Remove all discharge from ear
Instruct patient to keep ear dry
- Ear Drops
Antibiotics (Neomycin, Gentamycin, Ciproflox, Chlormycetin) + Steroid
3-4 times/day
Acetic acid irrigation
- Systemic Antibiotic
Used only during acute exacerbation (Amoxicillin, Ciprofloxacin)

SURGERY

- Myringoplasty \pm Ossicular reconstruction (when ear is dry)



ATTICO ANTRAL TYPE

- Medical management has limited role.
- Surgery is the mainstay of treatment



AIM OF SURGERY

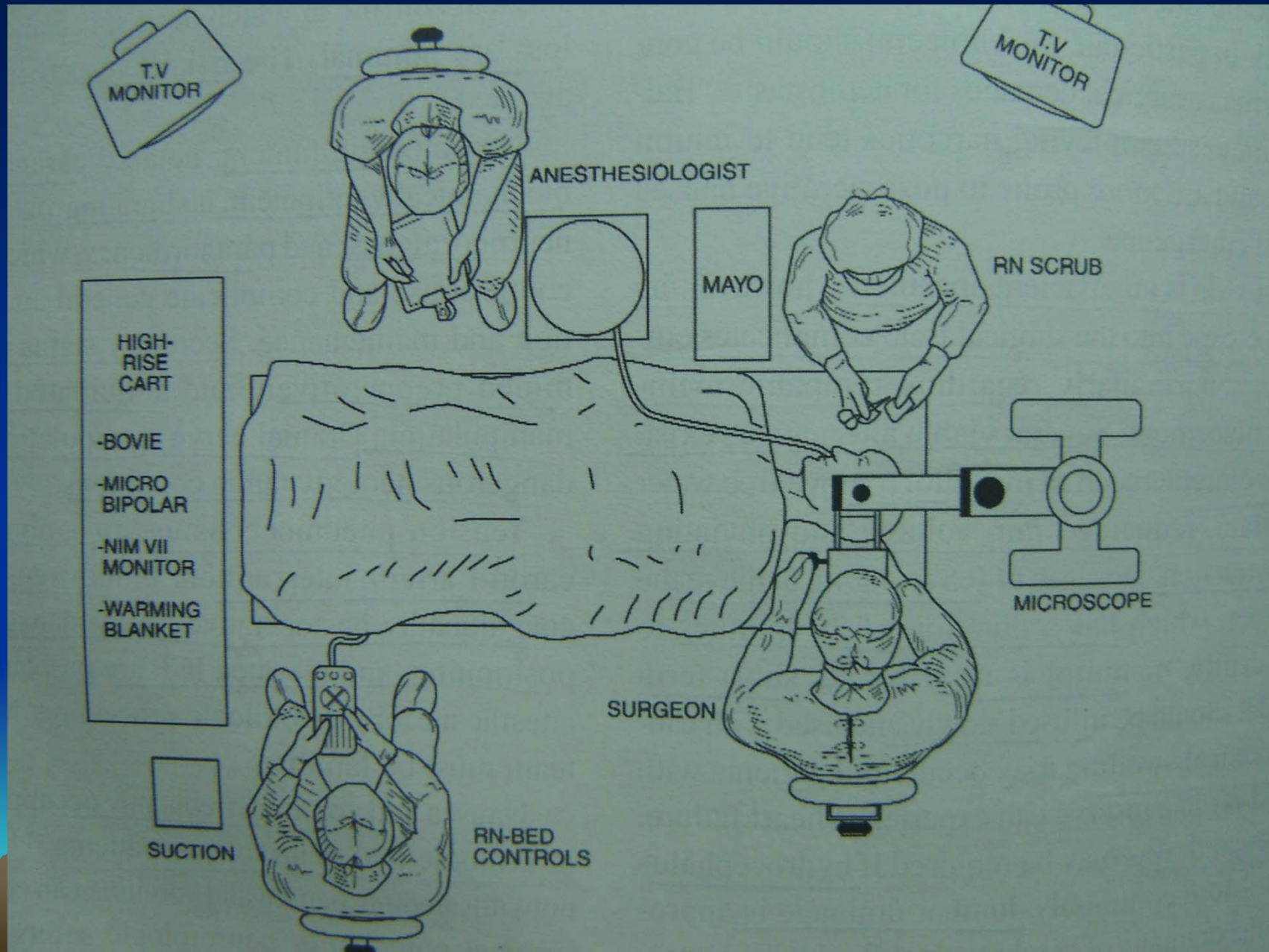
- To eliminate the disease and obtain a safe dry ear.
- To improve or preserve the hearing mechanism.



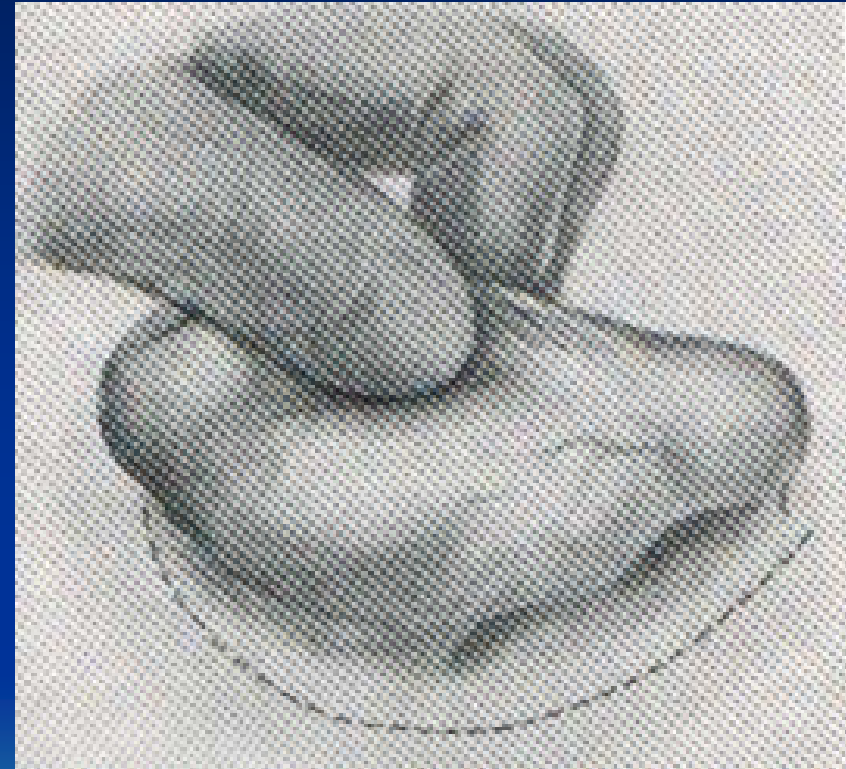
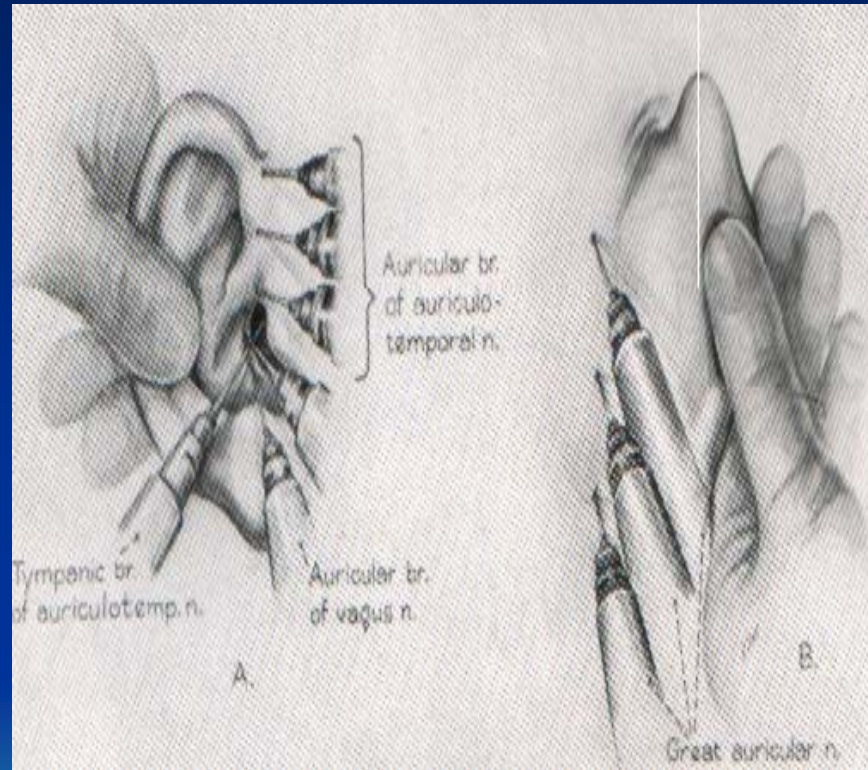
TYPE OF SURGERY

- Canal-wall-down procedures
 - Atticotomy
 - Modified radical mastoidectomy
 - Radical mastoidectomy
- Intact-canal-wall procedure
 - Cortical mastoidectomy
 - Combined approach tympanoplasty

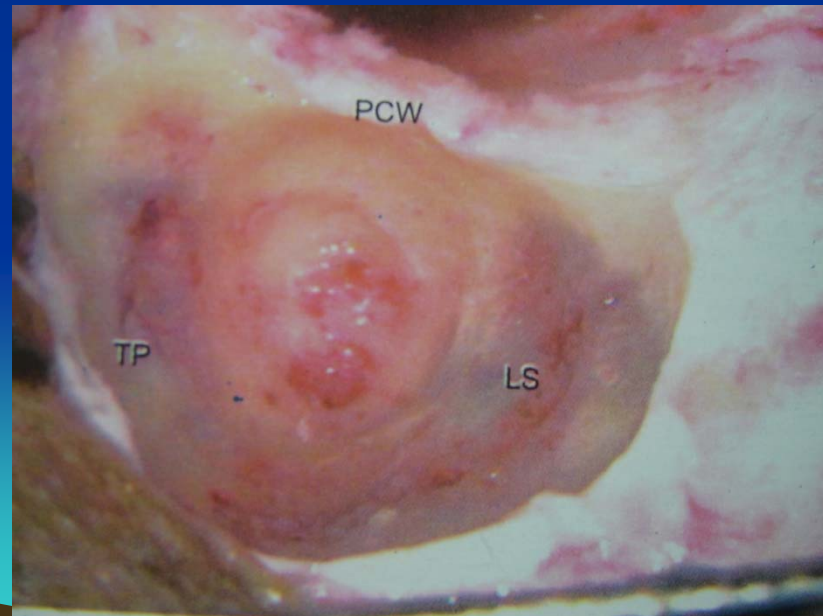
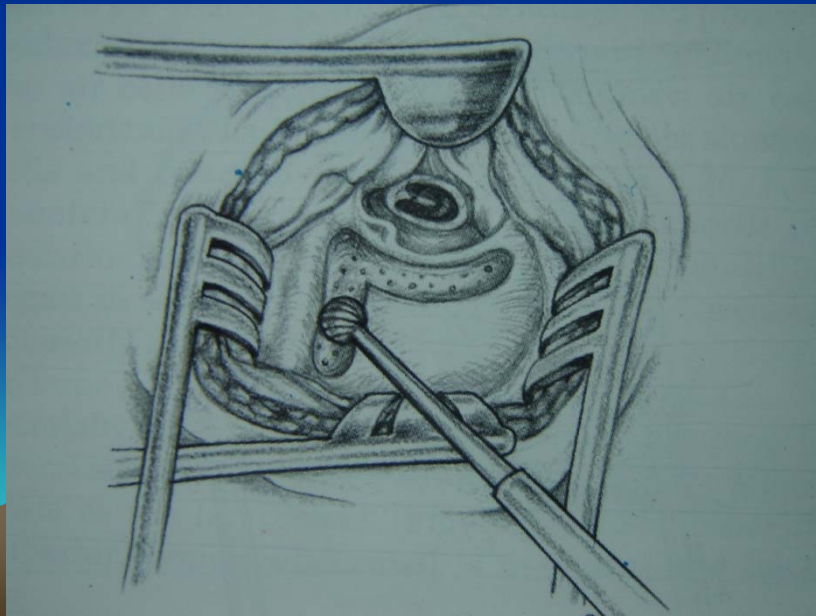
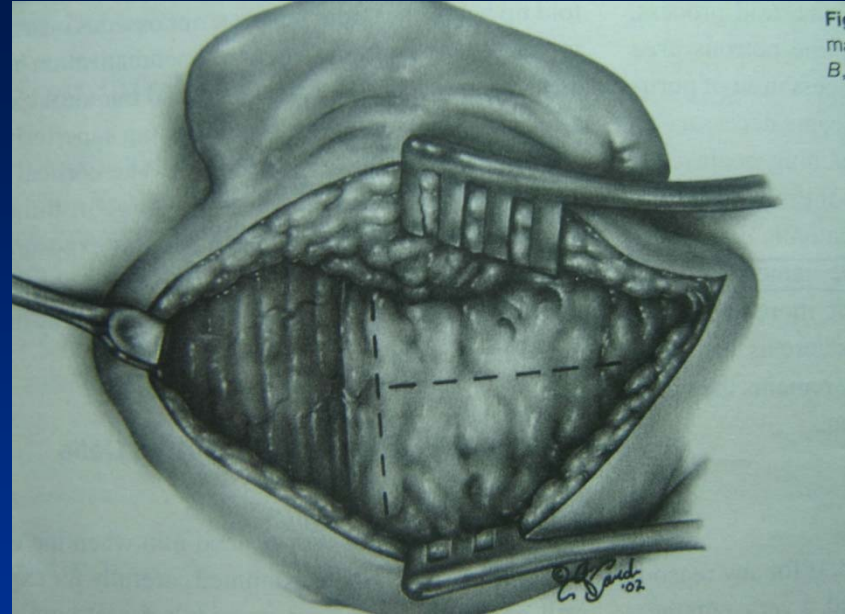
OT SET UP

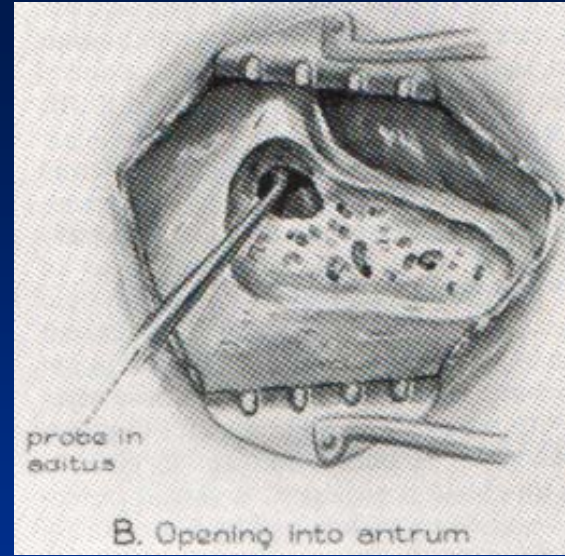
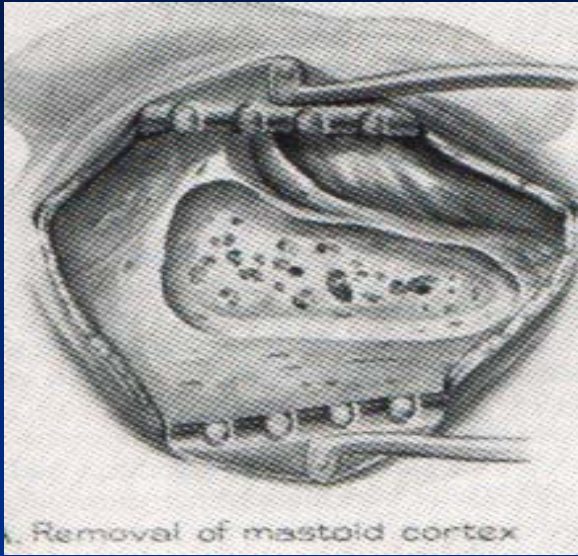


INFILTRATION & INCISION



INTACT-CANAL WALL PROCEDURE





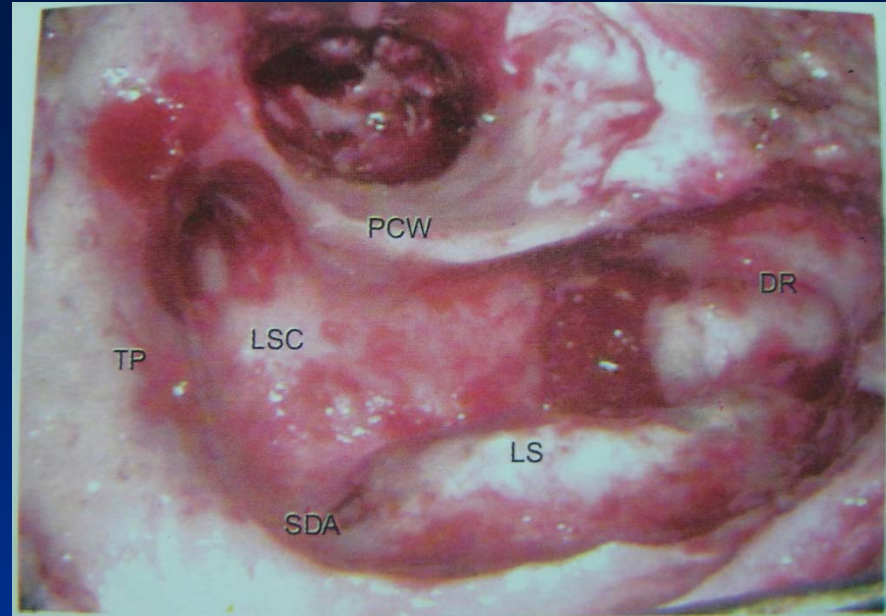
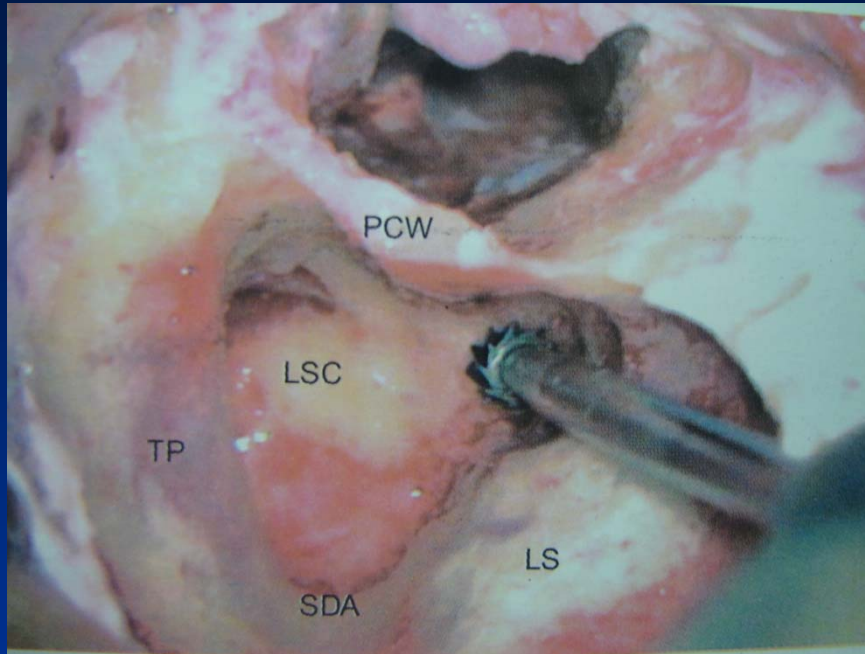
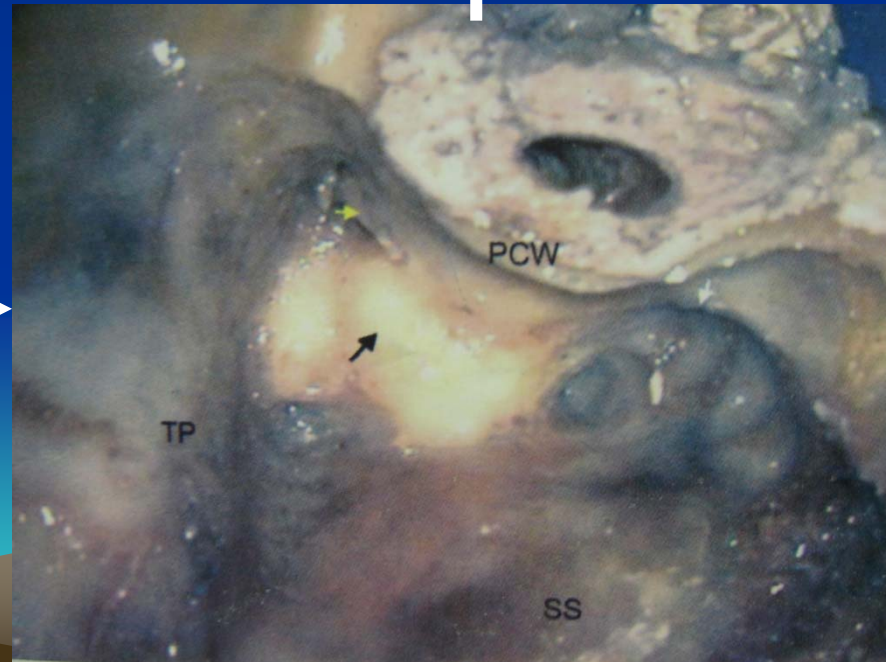
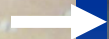
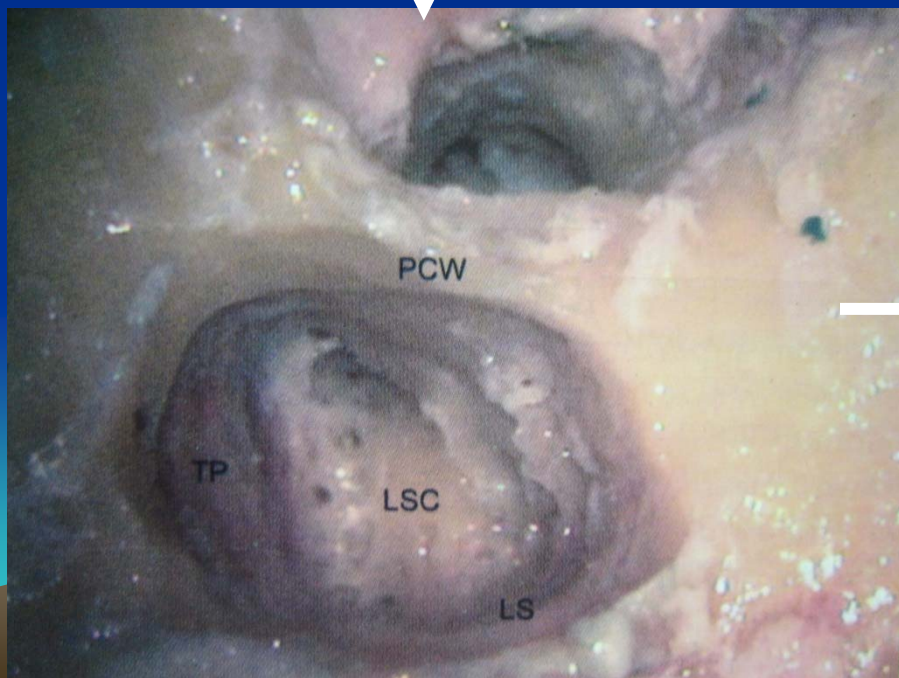
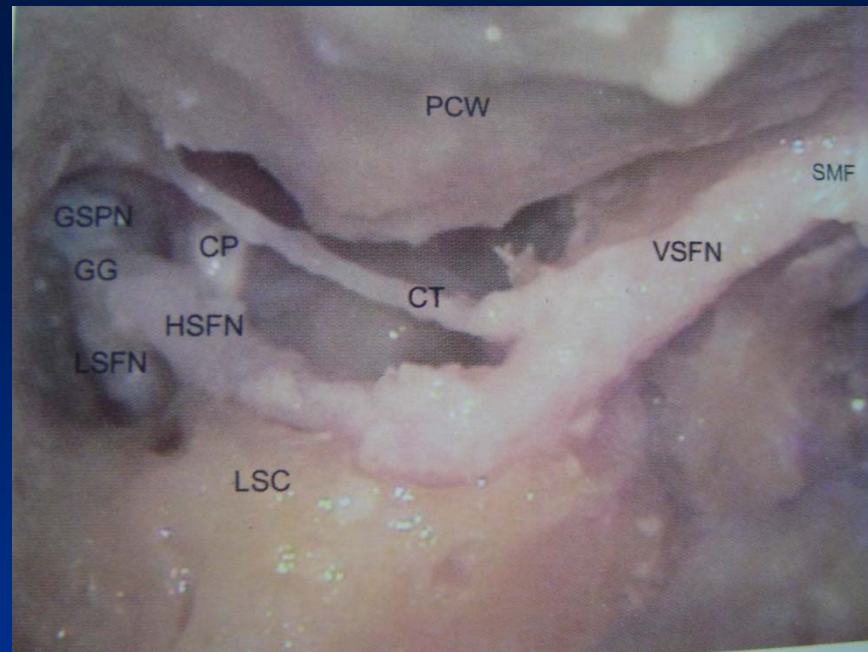
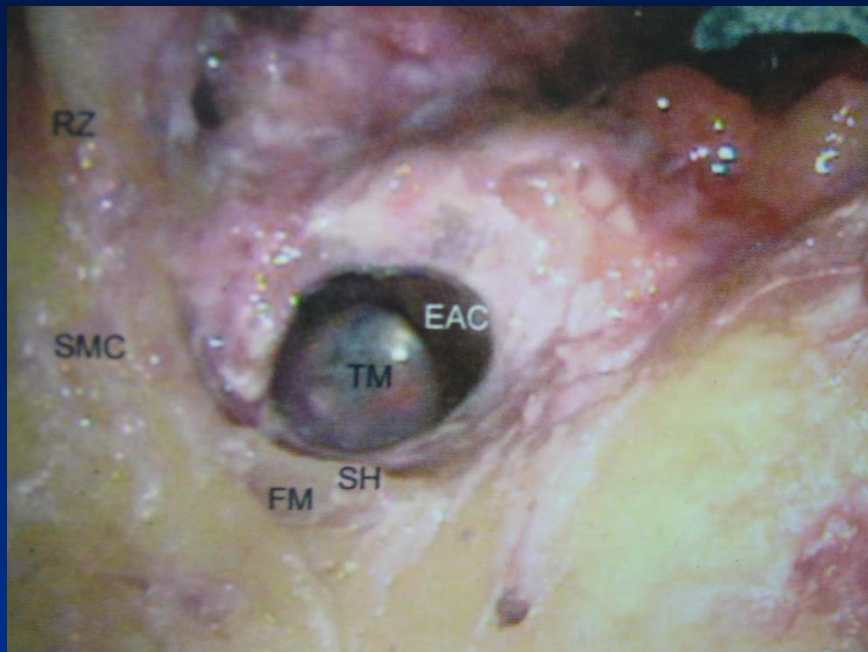
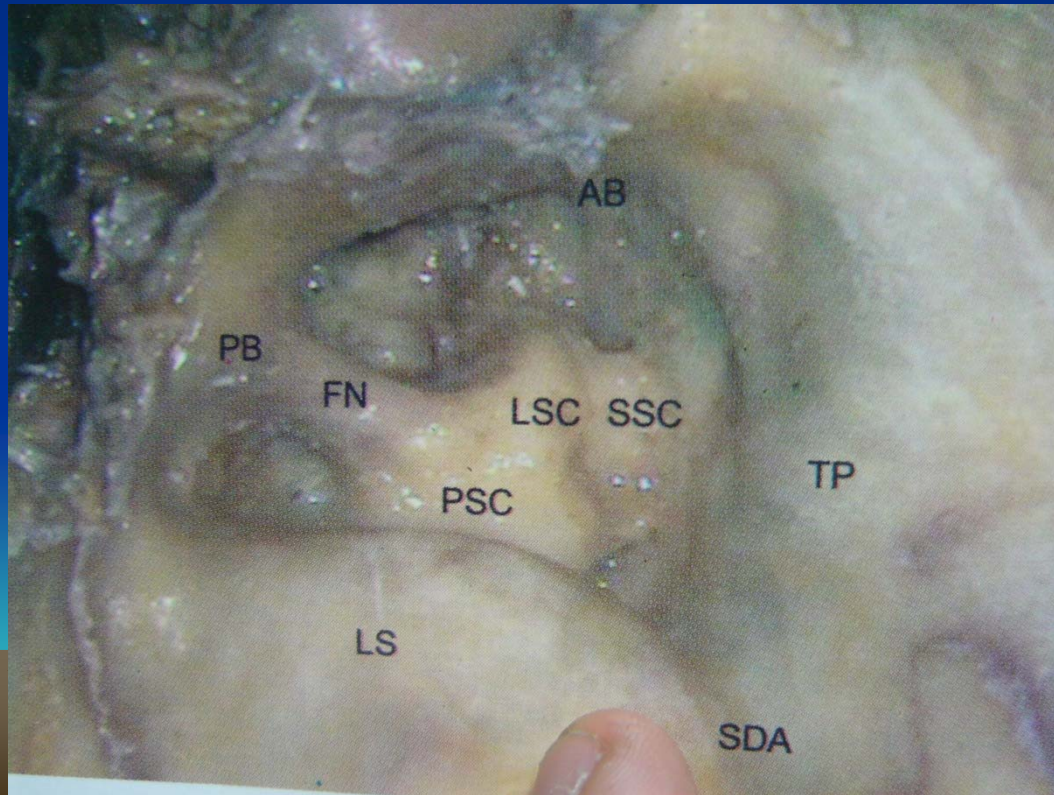
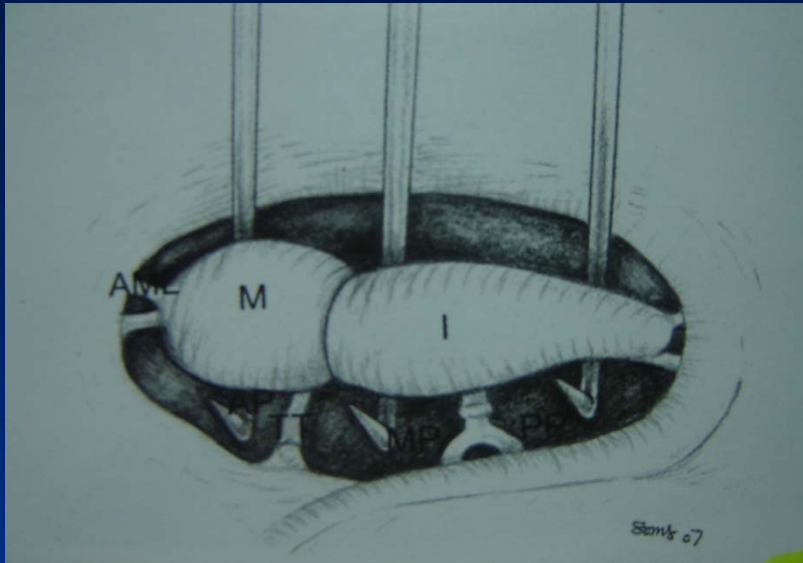


Fig. 8.33: Delineation of ligamentum gastroduodenale (DR) with exenteration of







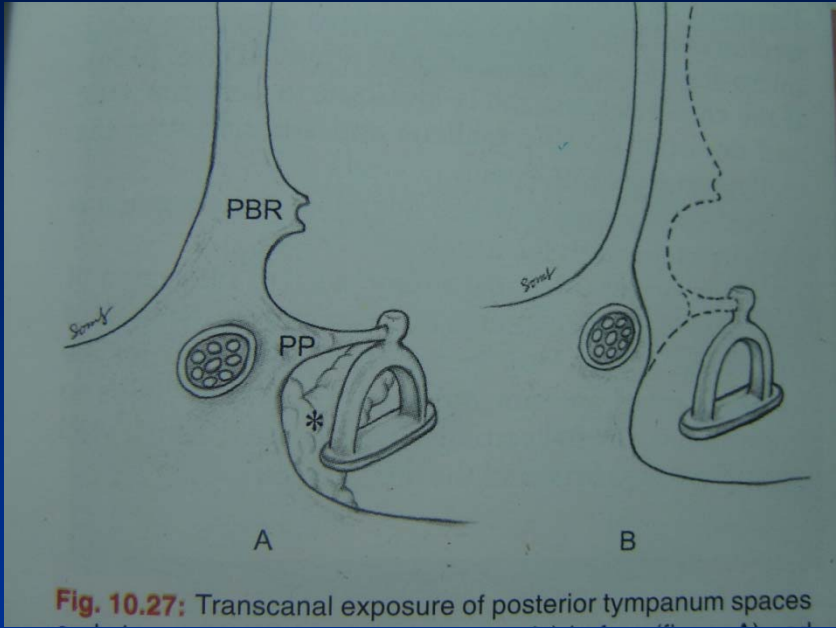
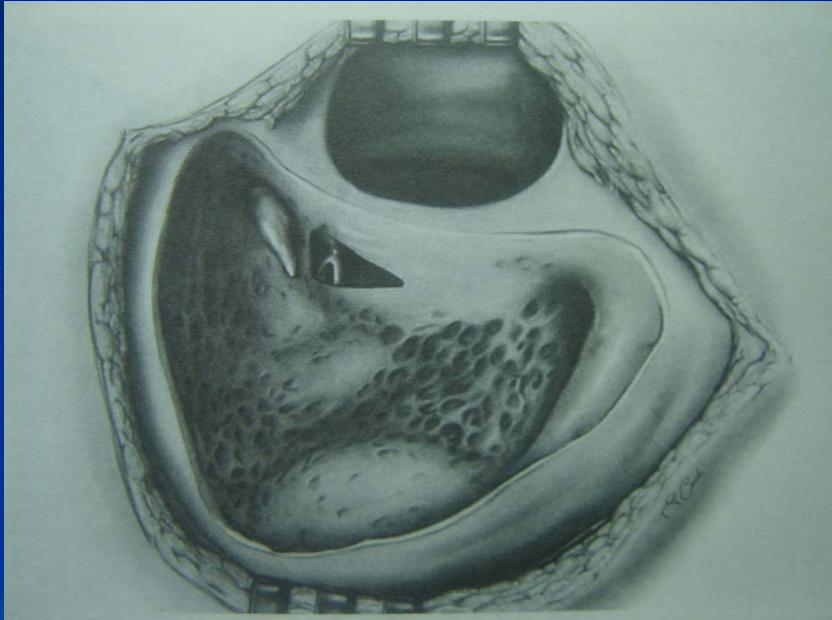


Fig. 10.27: Transcanal exposure of posterior tympanum spaces



THE IDEAL MASTOID CAVITY

- Small cavity
- Well saucerised
- Adequately lowered facial ridge
- Anterior and posterior buttresses removed
- No sharp edges
- Adequate Meatoplasty
- Intact tympanic membrane



POST OP CARE

- Mastoid dressing removal day 1
- Pre and post op antibiotics for about a week
- Suture removal at 6th day
- Pack removal at 1 week
- Thereafter pack at weekly intervals or leave unpacked with regular suction
- Regular follow up till epithelisation till about 2-3 months
- Periodic follow up every 4-6months for 1 year, then yearly
- Granulations ; if any to be managed by cautery

COMPLICATIONS

Abscess formation

- Post Aural abscess
- Bezold
- Lucs
- Citelli
- Subdural abscess
- Temporal lobe abscess
- Cerebellar abscess.
- Acute mastoiditis
- Labyrinthitis
- Facial nerve palsy
- Petrositis
- Lateral Sinus Thrombosis
- Otitic Hydrocephalus





THANK YOU





