0383: IJS CASE REPORT 2ND PRIZE: UNUSUAL PRESENTATION OF GLOMUS JUGULAR TUMOUR: A CASE REPORT AND LITERATURE REVIEW
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Introduction: We present the case of a 62 year old female with sudden onset left sided hearing loss, hoarseness and normal otoscopy. Flexible nasendoscopy revealed left vocal cord palsy, pure tone audiogram showed an ipsilateral dead ear. CT scan of the neck reported a left subglottic mass (Figure 1). No lesion was identified intra-operatively. Subsequent MRI of the skull base revealed a glomus jugulare tumour (Figure 2). Glomus jugulare tumours are neoplasms of the jugular bulb, classically associated with the rising sun sign.

Method: Advanced literature search of NHS evidence databases using the MESH terms glomus jugulare, paraganglioma, vocal cord palsy, dead ear and cerebellopontine was performed. Association between these tumours and cranial nerve pathology was well established with 37% manifesting cranial nerve involvement at presentation. 5% of patients will have vagus nerve involvement. Sensorineural deafness is present in 22% of cases. 40% of cases will be positive for the rising sun sign.

Results & Conclusions: To our knowledge this case report is unique as the first description of a case of glomus jugulare tumour presenting with vocal cord palsy in combination with dead ear. It also demonstrates the limited usefulness of the rising sun sign.

0458: A CASE OF PSEUDOHYPERKALAEMIA SECONDARY TO THROMBOCYTOSIS IN A PATIENT WITH GRUMBLING ABDOMINAL SEPSIS
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Aim: To increase awareness of pseudohyperkalaemia in surgical patients to prevent mismanagement.

Method: We report a case of pseudohyperkalaemia secondary to thrombocytosis in a patient with intra-abdominal sepsis.

Results: A 25 year old male patient was admitted to the ICU following a collision in which he suffered a perforated colon. Following a traumatic event the patient had a haemorrhage and required a blood transfusion. The patient was noted to have an increase in his haematocrit and haemoglobin levels. He was transferred to the ICU with a diagnosis of sepsis and thrombocytosis. The patient was treated with broad-spectrum antibiotics and blood transfusions. However, his haematocrit continued to rise to dangerous levels (6.3mmol/L). The patient was treated with serial dextrose/insulin infusions and salbutamol nebulisers, but failed to respond (K+ 6.5mmol/L 48 hours later). It was noted that the patient’s serum potassium level had begun rising. Despite the use of potassium-cherating resins orally, the serum potassium level continued to rise to dangerous levels (6.3mmol/L). He was treated with serial dextrose/insulin infusions and salbutamol nebulisers, but failed to respond (K+ 6.5mmol/L 48 hours later). It was noted that the patient’s platelet count had risen to 1748 due to the chronic sepsis (reactive thrombocytosis). The diagnosis of pseudohyperkalaemia was suggested; measurement of plasma potassium using a green-topped lithium bottle confirmed that the true level was only 3.6mmol/L. The patient was commenced on aspirin as thrombo-prophylaxis, hyperkalaemia treatment was stopped, and plasma potassium level rather than serum level was used to monitor progress.

Conclusion: Reactive thrombocytosis is common in surgical patients and may lead to pseudohyperkalaemia. Ignorance of this condition can lead to dangerous overtreatment.

0471: NICORANDIL ASSOCIATED COMPLICATIONS OF THE GASTRO-INTESTINAL TRACT: SIDE-EFFECTS REQUIRING SURGICAL INTERVENTION
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Aims: Nicorandil is increasingly identified, but under-reported, as a cause of anal ulceration, with an estimated incidence of around 4/1000 patients. Ulceration of the mouth, genitalia, skin, and gastro-intestinal tract has also been reported. The study aimed to report a mini-series of Nicorandil associated complications of the gastrointestinal tract (NAC-GIT) requiring surgical intervention.

Methods: All cases of NAC-GIT from one surgeon’s practice (2007-2012) who required surgical intervention were reviewed retrospectively.

Results: Three cases of NAC-GIT were identified within the study period. Case 1 - terminal ileum perforation requiring emergency small bowel resection and double-barrelled ileostomy. Case 2 - colonic ulceration masquerading as malignancy requiring laparoscopic left hemicolectomy and end colostomy. Case 3 - complex fistula-in-ano requiring multiple procedures for abscess drainage, seton insertion and laying open of fistulous tracts.

Conclusions: NAC-GIT remains an under-reported but increasingly identified side-effect, which can remain occult until significant complications ensue and necessitate surgical intervention in patients with significant operative risks. A standard approach for managing intra-abdominal or peri-anal sepsis is advised with an emphasis on safety when considering primary bowel Anastomosis versus stoma formation. Multi-disciplinary involvement is required when considering the peri-operative risks versus those of unresolved sepsis in patients with multiple co-morbidities.

0505: MALIGNANT TRANSFORMATION OF PLEOMORPHIC ADENOMA OF THE SKULL BASE – A DIAGNOSTIC AND MANAGEMENT CHALLENGE
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Objective: To present a unique case of primary pleomorphic adenoma (PA) of the anterior skull base that was initially diagnosed and managed as a left nasal cavity plexiform ameloblastoma. Subsequent expert review of the pathological specimen showed foci of adenocarcinoma. Case demonstrates advancements in transnasal endoscopic surgery for the resection of skull base tumours.

Case Report: Patient presented with left-sided nasal obstruction and blood-stained discharge. It was presumed disease recurrence following endoscopic resection of a plexiform ameloblastoma five years earlier. Subsequent repeat endoscopic biopsy suggested PA. Extensive transnasal endoscopic resection and further histopathological examination confirmed PA but foci of adenocarcinoma were also identified. Patient went on to have a transnasal endoscopic skull base resection. To our knowledge, this is the first reported primary PA of the skull base.

Discussion: Primary PA should be distinguished from other nasal tumour types. Complete excision is recommended to avoid recurrence and the possibility of malignant transformation. Avoiding excessive trauma to excised tissue/specimen is vital to ensure accurate histopathological diagnosis.

Conclusions: Primary PA of the skull base is exceptionally rare. High-quality specimen tissue is imperative for histopathological examination and consequent diagnostic purposes. Endoscopic management of skull base lesions is a safe, effective and preferable approach.

0506: THE USE OF PLEURX DRAINAGE IN RECURRENT SEROMAS
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Aim: To determine whether a PleurX drain could be successfully used in the management of a chest wall seroma.

Method: A 61 year old male, with a background of poorly differentiated carcinoma of the left chest wall, underwent chest wall resection and reconstruction. He presented to clinic 3 months post-operatively with a large chest wall seroma, which was aspirated but quickly recurred. A 15Fr tunnelled PleurX drain was suggested and the patient was re-admitted for insertion under a general anaesthetic.
Results: The patient made an uncomplicated recovery and was discharged home with regular district nurse input. At 2 months, the drain was removed with a good cosmetic result and no subsequent evidence of re-accumulation. Importantly, the patient was very satisfied with PleurX draining in the community and the final result.

Conclusions: We suggest insertion of a PleurX drain as a novel method for the management of chest wall seromas. This has not previously been described in the literature and in this case report, we demonstrate it to be safe and well tolerated. We suggest that further use in other surgical specialties is possible and that drains can be inserted under local anaesthetic as a day procedure.

0587: VASCULARISED FIBULAR GRAFT RECONSTRUCTION OF THE SPINE IN NEUROFIBROMATOSIS TYPE 1 DEFORMITIES: A REPORT OF TWO CASES
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Background context: The management of neurofibromatosis type 1 (NF 1) induced spinal deformity in the skeletal immature is challenging. There are no current definitive management consensus.

Purpose: To report a method using free vascularised fibular graft re-constructions (FVFG) for spinal reconstruction in severe NF1-induced spinal deformity.

Methods: Two case presentations followed by a literature review. Both cases were female patients, aged 15 (Case A) and 13 (Case B). Both had painful progressive, severe spinal deformity secondary to NF1 and were treated using FVFG. Case A had a primary spinal reconstruction whilst Case B was a secondary revision following previous failed fusion.

Results: Case B experienced right foot drop post-operatively due to cord oedema which later improved. At follow-up, a reduction in kyphosis from 70° to 20° for case A and 85° to 80° for case B were achieved. There was no donor site morbidity and both patients had no need for analgesia. Both had successful spinal fusion that arrested progressive deformity.

Conclusion: Free fibular grafts are an option to achieve fusion in these such cases involving severe deformities, regardless of whether primary reconstruction or a salvage procedure is required. We believe FVFG is superior to nonvascularised strut graft alternatives in this setting.

0803: A MIDFACIAL DEGLOVING APPROACH TO THE NASOPHARYNX: CASE PRESENTATION AND DISCUSSION OF SURGICAL TECHNIQUE
Sam Haddad, Saleh Okhovat, Jonathan Hughes, Peter Clarke. Charing Cross Hospital, London, UK.

Objectives: Nasopharyngeal adenocarcinoma is a rare subtype of nasopharyngeal carcinoma. It is typically insensitive to chemo-radiotherapy, and therefore requires surgical treatment. We describe a case of nasopharyngeal adenocarcinoma treated with surgical resection through a midfacial degloving (MFD) approach.

Methods: A 58-year-old Iraqi woman presented to our department with unilateral conductive hearing loss. Examination revealed a right-sided middle ear effusion and post-nasal space (PNS) mass. Histology of PNS biopsies demonstrated a low-grade adenocarcinoma of salivary gland origin. Magnetic resonance imaging displayed a lobulated mass centred around the pharyngeal recess with skull-base extension. The patient underwent an MFD approach to the nasopharynx and clearance of the infra-temporal fossa.

Results: We describe the development of MFD as a surgical technique to access the PNS and skull-base. Through the use of schematic illustrations we depict steps in this surgical approach and relevant clinical anatomy. We review its application, outcomes and complications within the current literature, in comparison to other techniques.

Conclusions: Unilateral conductive hearing loss in adults is suspicious for malignancy and prompts thorough investigation of the PNS. Surgical access to this region is difficult owing to its central location and complex surrounding anatomy. MFD provides adequate access and is associated with good post-operative outcomes and fewer complications.

0823: AN ALTERNATIVE METHOD OF REMOVING AN ENDOBRONCHIAL BLOOD CLOT IN A LARYNGECTOMY PATIENT
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Introduction: Endobronchial blood clot causing airway obstruction is a rare but potentially life-threatening condition and can occur in a variety of clinical settings.

Presentation of case: A male laryngectomee, with a background of bronchogenic carcinoma was treated conservatively for tracheitis following an episode of upper respiratory tract infection. However, he later developed airway obstruction secondary to endobronchial bleeding with endobronchial clot formation. Conventional methods of suctioning and rigid bronchoscopy with forceps failed to remove the haematoma. A Fogarty embolectomy catheter was used to remove the haematoma, relieving the airway obstruction.

Discussion: The Fogarty embolectomy catheter has been widely used in various vascular operations for removal of arterial and venous emboli over the last years. However its application in non-vascular cases is not widely published.

Conclusion: We report a case of tracheitis, complicated by an endobronchial clot in a laryngectomy patient, and demonstrated the use of Fogarty embolectomy catheter in such case when conventional methods fail.

0931: THE PERILS OF POLLY – THE MANAGEMENT OF PARROT BITE INJURIES: A CASE REPORT
Hannah Freeman, Ian King, James Wokes. James Cook University Hospital, Middlesbrough, UK.

Introduction: Parrot bites are uncommon causes of hand trauma with a different pathophysiology to human, cat and dog bites and hence require a different management plan. Parrot bites can cause psittacosis, pasturellosis and nontuberculous mycobacteriosis.

Aims: With review of the literature, we discuss the organisms involved, how they present and offer guidelines for managing this potentially serious injury.

Methods: A PubMed search was performed to identify previous case reports and treatment recommendations. Microbiology advice was sought and the patient treated appropriately.

Results: No antibiotic guidelines were found on searching the medical literature. The main organisms in parrot bites are Chlamydophilia psittaci; causing Psittacosis and Pasturella multocida; which causes pasturellosis and nontuberculous mycobacteriosis. Tetracyclines are the first line recommended antibiotics in psittacosis and pasturellosis. Co-Axomixlav has a role for prophylaxis in severe injuries.

Conclusions: Parrot bites are uncommon causes of hand trauma. Conventional treatment with Co-Axomixlav is ineffective against the Chlamydophilia psittaci and Pasturella multocida transmitted via parrot bites. No treatment algorithm exists in the literature for these injuries. We recommend Doxycycline as first line treatment for superficial injuries. More severe injuries require surgical debridement, washout and dual antibiotic prophylaxis with Co-Axomixlav and Doxycycline.

0998: SPILLED GALLSTONE FOLLOWING LAPAROSCOPIC CHolecystecToMY PRESENTING AS A PORT SITE Hernia
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Introduction: Gallbladder perforation and spillage of gallstones is a complication that occurs more frequently in laparoscopic than open cholecystectomy.

Case Presentation: We present a case of a 61 year old female with a painful lump at her lateral port-site four years following laparoscopic cholecystectomy. Ultrasonography revealed a hypoechoic density and she was listed for an elective hernia repair. On her day of admission the lump at her lateral port-site four years following laparoscopic cholecystectomy was noted which opaciﬁed for an elective hernia repair. She was diagnosed with a port-site hernia.

Discussion: Port-site hernia is a complication that is known to occur with laparoscopic surgery. However, it is rare to occur four years following the initial surgery. This case highlights the importance of preoperative imaging and the need for a high level of suspicion when investigating port-site hernias.