**Case study:** This lady presented with haematemesis. Gastroscopy showed a pulsatile mass in the pharynx. CT imaging identified a left common carotid artery fistulating into the pharynx. Collaborative emergency repair was undertaken involving vascular, ENT, plastics and radiology specialists.

To control bleeding, the common carotid artery was initially stented using a Viabahn stent, currently not licenced for use in carotid vessels. This was followed by exploration of the neck, bovine patch repair of the carotid and repair of the pharyngeal defect with a myodermal flap. Post-operative recovery was uneventful.

**Conclusion:** Of the two previously reported cases, one survived, but underwent coil embolisation of the internal carotid artery. Although not licenced for this purpose, stenting the common carotid artery prevented haemorrhage and maintained cerebral perfusion in this rare case. Ligation of the common carotid artery would have carried a significant risk of stroke. This emphasises the potential benefits from using off licence stents when deemed clinically necessary.

**0235: A RARE MANIFESTATION OF AN UNCOMMON DISEASE: A CASE OF SARCOIDOSIS PRESENTING AS VOCAL CORD PALSY**

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**Introduction:** Hoarseness is a common presentation to the Otolaryngologist. The aetiology of this symptom can be a diagnostic challenge due to the vast range of potential diagnoses. Vocal cord paralysis is a rare complication of sarcoidosis; and its initial presentation with hoarseness due to vocal cord paralysis has been rarely reported.

**Case study:** A 40-year-old woman was referred to Otolaryngology with a three-month history of persistent hoarseness of voice. Clinical examination was grossly normal. Fibre-optic laryngoscopy revealed an immobile left vocal cord -- indicating left vocal cord palsy. Computerised tomography scan showed bilateral hilar and mediastinal lymphadenopathy but no evidence of compression to the recurrent laryngeal nerve. Histological assessment via mediastinoscopy and biopsy revealed granulomatous lymphadenitis with morphological features diagnostic of sarcoidosis. Sarcoidosis causing mediastinal lymphadenopathy compressing the recurrent laryngeal nerve has been previously reported. However, this presentation of mono-neuritis secondary to sarcoidosis is rare.

This patient was treated with systemic corticosteroids and later speech therapy.

**Conclusion:** This case highlights a rare presentation of a multi-systemic disease, the need for a breadth of clinical knowledge by specialists and the importance of a multi-disciplinary team approach to patient care.

**0276: PROXIMAL SMALL BOWEL OBSTRUCTION AND STRONGYLOIDES**

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**Introduction:** An estimated 100 million people worldwide are infected by the parasitic helmint, Strongyloides stercoralis. Resultant strongyloidiasis is typically asymptomatic but can potentially cause intestinal obstruction.

**Case study:** A 52 year-old man from Grenada with a history of HTLV-1 presented to our safety-net hospital with colicky abdominal pain, bilious vomiting, and anorexia. An abdominal CT showed a high-grade proximal small bowel obstruction and an upper GI series demonstrated circumferential thickening and narrowing of the proximal small bowel. Subsequent esophagogastroduodenoscopy found inflammation and narrowing of the 3rd portion of the duodenum with no evidence of discrete mass. Biopsy of duodenal mucosa showed strongyloidiasis infection. He was treated with ivermectin and albendazole and his obstruction resolved. Duodenal obstruction from Strongyloides is a reported but rarely considered cause of small bowel obstruction. Patients tend to be middle-aged males from endemic regions (Latin America, Caribbean Sub-Saharan Africa and Southeast Asia), often with longstanding symptoms and comorbid immunologic disease. Anthelmintics are the treatment of choice.

**Conclusion:** Strongyloidiasis should be ruled out in patients with distal duodenal and proximal small bowel obstructions. This is particularly important for physicians working in settings that serve a disproportionate amount of patients from regions where strongyloidiasis is endemic.

**0279: A CASE LINKING OBSTRUCTIVE SUBMANDIBULAR SIALADENITIS TO POTENTIAL AIRWAY COMPROMISE**

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**Abstract:** A 35-year-old man presented with one-day history of dysarthria, dysphagia and right temporal headache. He had a percutaneous drainage and antibiotic treatment of a sigmoid diverticular abscess 7 months previously. MRI brain showed a right frontal motor cortex lesion, which was initially diagnosed as glioma. A CT angiogram was then performed but showed no vascular abnormality in relation to this lesion. The images were subsequently discussed in the Neurosurgical MDT. A brain abscess with cerebritis and cerebral oedema was diagnosed. A CT scan of abdomen and pelvis later showed an abscess formation in the distal sigmoid colon.

**Conclusion:** The patient underwent a right fronto-parietal mini-craniectomy and evacuation of cerebral abscess, followed by Hartmann's procedure. The abscess cultures both grew Streptococcus Anginosus. He made a full neurological recovery and was discharged with outpatient parenteral antibiotic therapy.

**0257: ACUTE INTRA-ABDOMINAL HAEMORRHAGE: BEWARE OF RED HERRINGS**

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**Introduction:** We report the case of a male aged 20 presenting with central acute abdominal pain after being punched around his umbilicus during a boxing match the day previously.

**Case study:** On admission he was haemodynamically stable with a normal haemoglobin. He underwent a CT scan, indicating a grade three splenic laceration. After a period of observation he became haemodynamically unstable and dropped his haemoglobin. He was subsequently taken to theatre for an emergency laparotomy and splenectomy.

Laparotomy found massive blood loss into all four quadrants of the intra-abdominal cavity. The spleen was examined and the laceration was evident, however there was no active bleeding. The laparotomy was continued and with examination of the bowel a giant (15 cm) Meckel's diverticulum was discovered with rupture of its blood supply causing the bleeding. This was resected and the bowel Anastomosed. The patient went on to recover well.

**Conclusion:** This case demonstrates the importance of being aware of uncommon presentations of pathology. It also highlights the dangers of over relying on imaging. In this case the splenic laceration served as a red herring, detracting from the true cause of this patients symptoms caused by an unusually large bleeding Meckel's diverticulum.