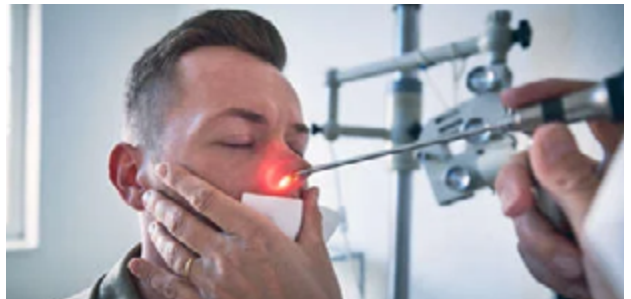

Accepted Abstracts

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Inside the award-winning film “Can You Hear My Voice?” - A life-altering surgery, a choir without voice boxes, and the human capacity for resilience

Bill Brummel

Bill Brummel Productions, USA

Filmmaker Bill Brummel (Peabody Award, International Documentary Association Awards, Emmy nominations, Oscar shortlist) explores the psychosocial issues faced by patients after a laryngectomy and by other head & neck cancer survivors. Brummel is a 26-year cancer survivor who lost his voice box in 2016 due to long-term damage from prior radiation treatments. Subsequently, he produced and directed “Can You Hear my Voice?”

The psychosocial consequences of cancer survivorship are challenging, especially when treatments leave a patient physically altered in a noticeable way. Laryngectomized patients experience anxiety, depression, and lack of confidence, and tend to socially withdraw. Using illustrative

film clips, Brummel weaves themes from the movie with his own story of survivorship. He addresses the trauma of forever losing your natural voice and breathing through a stoma. But through carefully selected film scenes (including the jubilant concert finale) and Brummel’s own story, he offers an inspirational blueprint for how to thrive after a life-threatening cancer diagnosis and a laryngectomy. He does so with empathy, compassion, and humor.

“Bill Brummel is a powerful speaker and advocate...” Judith Lacey, Supportive care and integrative oncology physician, Chris O'Brien Life house, Sydney, Australia.

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Pneumomediastinum and pneumothorax following micro laryngoscopy

Howard Webb

Austin Health, Australia

Micro laryngoscopy is a very common and relatively safe procedure performed frequently by otolaryngologists. A 50-year-old female presented to our health service for micro laryngoscopy and laser excision of bilateral Reinke's edema. The patient had a significant smoking history and was experiencing soft stridor at rest and severe dysphonia. The patient underwent oral intubation, and suspension laryngoscopy was performed using a Dedo scope. Laser excision of Reinke's edema was performed bilaterally, and the patient was transferred to the post-operative bays. No accidental mucosal laser injury was noted during the operation. However, in recovery, the patient became dyspneic and required oxygen via a Hudson mask due to hypoxemia. Clinical examination revealed extensive subcutaneous emphysema, however, flexible nasoendoscopy showed a normal post-operative appearance of the vocal cords and subglottis, with no airway compromise. Chest

x-ray and computed tomography scan revealed a small pneumomediastinum and small bilateral pneumothoraces, as well as extensive subcutaneous emphysema, centered around the vocal cords. The patient was transferred to the intensive care unit in a stable condition; however, 6 hours postoperatively was severely fatigued due to increased work of breathing and was intubated. The patient remained intubated until day four postoperatively and was discharged from the hospital on day eight postoperatively. Although no laser injury to the larynx was noted intraoperatively, it is presumed that the resultant pneumomediastinum was a complication of the laser excision of Reinke's edema. This case reminds us that even the most routine airway surgeries carry risk, and in all surgery, no matter how routine, unexpected complications can arise.

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Association of ultrasonographic characteristics with the malignancy in cold nodules of the Thyroid

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Methods: This was an observational study, conducted in the Department of ENT, Jinnah Postgraduate Medical Center, Karachi. The study duration was six months, ie. from 15th April to 15th October 2019. Patients with a diagnosis of the palpable thyroid gland on physical examination were enrolled. Detailed histories and physical examinations were recorded. All patients underwent ^{99m}Tc-pertechnetate scintigraphy and patients with cold nodules were eligible for study after fulfilling inclusion/exclusion criteria. Thyroid ultrasonography was performed and findings such as size, shape, calcifications, and hypoechogenicity of nodules were recorded. FNA biopsy was performed under ultrasound guidance. The final diagnosis of malignancy was based on histopathologic examination. Data were analyzed by SPSS and the association was established between ultrasonographic characteristics and frequency of malignancy in cold nodules of the thyroid gland.

Results: Out of the total of 188 patients with cold nodules, 17 were positive for malignancy. On analysis of the association of various factors with malignancy, 04 patients of age less

than 40 years while 13 of age 40 and above had malignancy (P= 0.235). Ten males and 7 females had malignancy (P= 0.514). Seven patients with tumor size > 20 cm, while 10 patients with tumor size > 20 cm had malignancy (P=000). Fourteen patients with abnormal shapes while 03 patients without abnormal shapes had malignancy (p=.036). Seven patients with calcification while 10 patients without calcification had malignancy (P=0.209). Seven patients with hypoechogenicity while 10 patients without hypoechogenicity had malignancy (P=0.533).

Conclusions: The majority of patients with malignancy are males of above 40 years of age. Tumor size above 20 cm and abnormal shape on ultrasound of the thyroid gland is strongly associated with increased chances of malignancy in cold nodules of the thyroid.

Keywords: thyroid malignancy, cold nodule, ultrasonography, FNA biopsy, tumor histopathology.

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Discovery of a rare aberrant artery overlying Trachea during open Tracheostomy

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Tracheostomy is a common surgical procedure for securing a patent airway. Although the discovery of anatomical variations of major vessels overlying the trachea is rare, this may pose a significant bleeding risk during the procedure. Hence, a thorough preoperative assessment of the neck and the surgeon's intraoperative vigilance is essential. Open tracheostomy is a safer option than percutaneous dilatational tracheostomy. The higher the level of insertion of the tracheostomy tubes, the less likely the chance of damage to a major artery. Furthermore, cricothyroidotomy could be regarded as having the minimal chance of injuring major vessels compared with tracheostomy in emergency

management of the unanticipated difficult airway. In addition, the arteries that are of particular importance due to their close anatomical relationship with the trachea, namely the tortuous versions of normally positioned vessels, the innominate artery, the right and left common carotid arteries, the right subclavian artery, the thyroid ima artery and the aberrant right subclavian artery (ARSA). Last but not least, extra caution with stoma wound care and change of tracheostomy tube is necessary postoperatively if any major vessel is detected in close proximity to the tracheal stoma.

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