Case : 1

Pradeep 44 year old Male

Place : Kombara

Occupation : electrician.

Chief presenting complaint :-

Nasal obstruction in the left nasal cavity for one week.

History of presenting illness :-

Patient was apparently normal one year back, then he noticed nasal obstruction in the left nasal cavity, associated with breathing difficulty. Nasal obstruction was insidious in onset and gradually progressed. No aggravating or relieving factor. Two weeks back he had history of fever, nasal discharge and post nasal drip, and tested positive for Dengue. Nasal discharge was mucopurulent in nature and profuse. It was acute in onset and gradually progressed.

One week back he started developing breathing difficulty due to left nasal obstruction. He give history of loss of smell since one year.

No history of sneezing, epistaxis, headache or facial pain
No history of change in voice.
No history of foreign body insertion, wheezing, dental infection or carries tooth.

Past history.

H/o DM and Hypertension for one year, not taking any medication
No H/o any surgery.
No H/o TB, syphilis, bronchial asthma, CAD.
No H/o drug allergy.

Family history.

No significant family history.

Personal history :-

Mixed diet, appetite normal, sleep is disturbed, bowel and bladder normal.

No addictions / drug allergies.

General examination.

Patient is co-operative and well oriented to time, place and person. Moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy, edema, skin and hair normal, thyroid normal.

Vitals → stable.

Systemic examination :- All systems within normal limits.

Examination of Nose.

A] Physical examination :-

	Right	Left.
- Skin and osteo-cartilaginous framework	normal	normal.
- Vestibule, ala and columella	Normal	Normal.
- Anterior rhinoscopy :-		
Nasal passage	normal	reduced.
Septum	normal	normal.
Floor of nose	normal	normal.
Lateral wall	normal	white glistening mass, discharge seen.

Roof	not seen	not seen.
Probe test	not done	not done.
Posterior rhinoscopy	not done	not done.

B] Functional examination of nose.

Cold spatula test	normal	Reduced fogging.
Sense of smell	Absent	Absent.
Cottle's test	Negative	negative.

Examination of Paranasal sinus :-

Inspection

- Forehead, orbital margins, orbit and its contents, roof of nose, cheek, lips, etc	Normal	Normal.
• Vision	normal	normal.

Palpation

Sinus tenderness	Absent	Absent.

Examination of ear.

	Right	Left:
Pinna	Normal	Normal.
Pre auricular region	normal.	normal.
External auditory canal	normal	normal.
Tympanic membrane	normal	normal.
Tragal tenderness	Absent	Absent.
Mastoid tenderness	Absent	Absent.

Functional examination :-

Tuning fork tests :-

Rinne test - Positive in both ear.

Weber test - Centralized

ABC - normal in both ear.

Fistula test - Negative.

Facial nerve : - normal.

Visual field - normal.

Examination of oral cavity and throat :-

Lips : normal.

Teeth and gums : normal.

Gingivo-labial sulcus :- normal.

Buccal mucosa and palate :- normal.

Tongue and floor of mouth :- normal.

Tonsil and pillars : normal.

Posterior pharyngeal wall : normal.

Examination of neck.

Inspection :

- No visible scars, sinuses, dilated veins, Pulsations, swellings.
- Neck movements and movements with respiration and deglutition normal.

Palpation :

- No local rise of temperature.
- No palpable lymph nodes.
- Laryngeal crepitus - present.

SUMMARY

44 year old male patient came to OPD with complaints of left nasal obstruction. It was insidious in onset and gradually progressed. O/E vitals are stable, white glistening mass and mucopurulent discharge seen in left nasal cavity, There is reduced fogging on left side on cold spatula test.

Diagnosis :-

Ethmoidal polyp in the left nasal cavity.

Case : 2

Vishnu , 22 /M

Place : Piravam.

Occupation :- Traffic police.

Chief presenting complaint :-

Nasal obstruction in the right nasal cavity for 1 week.

Nasal discharge for one week.

History of presenting illness :-

Patient was apparently normal 2 month back, then he noticed nasal obstruction in the right nasal cavity, associated with breathing difficulty. Nasal obstruction was insidious in onset and gradually progressed. No aggravating or relieving factors.

One week back he developed nasal discharge, which was acute in onset gradually progressed, mucopurulent in nature. He also complaints of difficulty in sleeping due to right nasal obstruction.

No history of sneezing, epistaxis, Headache or facial pain.

No history of change in voice.

No hlo foreign body insertion, wheezing, dental infection or carries tooth.

Past history :-

No history of similar condition in the past.

No hlo DM, HTN, TB, syphilis, bronchial asthma, CAD

No hlo any surgery, drug allergy.

Family history.

No significant family history.

Personal history :-

Mixed diet, appetite normal, sleep is disturbed, bowel and bladder normal.

No addictions / drug allergies.

General examination.

Patient is co-operative and well oriented to time, place and person. Moderately built and nourished.

No pallor, icterus, cyanosis, clubbing, lymphadenopathy, oedema.

Skin and hair normal, thyroid normal.

Vitals stable.

Systemic examination :- All systems within normal limits.

Examination of Nose

A] Physical examination :-

	Right	left.
- Skin and osteo-cartilagrous framework.	Normal.	Normal.
- Vestibule, ala and columella	Normal	normal.
- Anterior rhinoscopy :-		
Nasal passage.	narrow	normal.
septum	Deviated to right side.	
Floor of nose	normal	normal.
Lateral wall	White glistening mass, discharge seen.	Small sized mass.

Roof	not seen	not seen.
Probe test	not done	not done.
Posterior rhinoscopy	not done	not done.

Examination of Paranasal sinus :-

	Right	left.
Inspection :		
Forehead, orbital margins, orbit and its contents, roof of nose, cheek, lips etc	normal	normal
Vision	normal	normal.
Palpation :		
sinus tenderness	Absent	Absent.

Examination of ear :-

	Right	left.
Pinna	normal	normal
Pre-auricular region	normal	normal.
External auditory canal	normal	normal.
Tympanic membrane	normal	normal
Tragal tenderness	Absent	Absent.
Mastoid tenderness	Absent	Absent.

Functional examination :-

Turning fork tests :-

Rinne test : negative Positive on both ear.

Weber test - centralized.
ABC - normal in both ear.
Fistula test - negative.
Facial nerve - normal.
Visual field - normal.

Examination of oral cavity and throat :-

Lips - normal.
Teeth and gums - normal
Gingivo-labial sulcus - normal
Buccal mucosa ad palate - normal.
Tongue and floor of mouth : normal.
Tonsil and pillars : normal.
Posterior pharyngeal wall : normal.

Examination of neck.

Inspection:

- No visible scars, sinuses, dilated veins, pulsations, swellings.
- Neck movements and movements with respiration and deglutition normal.

Palpation :

- No local rise of temperature.
- No palpable lymph nodes.
- Laryngeal crepitus - Present.

SUMMARY.

22 year old male patient came to OPD with complaints of right nasal obstruction. It was insidious in onset and gradually progressed. O/E vitals are stable, white glistening

mass seen in the right nasal cavity and small mass in the left nasal cavity associated with mucopurulent nasal discharge. There is reduced hearing on right side on cold spatula test. Nasal septum is deviated to right.

Diagnosis :-

Bilateral ethmoidal polyp and DNS to right.

Case : 3

Name : Kaushalo.

Age : 49 years.

Sex : Female.

Address :- Malayatoor.

Occupation :- Daily wage labourer.

Chief presenting complaint :

Pain in the right ear for past 2 years.

History of presenting illness.

Patient was apparently normal 2 years back. Then she presented with a pain in right ear, acute in onset and gradually progressed to the left ear. The pain increased during cold whether and also when she carried load on her head and it get relieved on application of ear drops.

It was also associated with mucopurulent discharge when water enter her ear which is profuse in quantity and no foul smell is associated with it.

She also complaints of decreased hearing and headache. She gave a history of increased dizziness when she bents down.

No history of blood stained discharge, bleeding, ringing sensation in ear, fever, allergy, sore throat, nasal block.

Past medical and surgical history :

No H/o similar complaints in the past.

She is hypertensive patient and is taking medication for the same.

No history of diabetes mellitus, dyslipidemia, thyroid disorders.

No history of previous surgeries.

Family history:

No relevent family history.

Personal history:-

Mixed diet.
sleep and apetite - normal
bowel and bladder habits :- regular.

General examination:-

Moderately built and nourished.
co-operative.
No pallor, icterus, cyanosis, clubbing, lymphadenopathy, edema.
BP - 140/90 mm Hg on right arm supine position.
Pulse, temperature, respiratory rate normal

Systemic examination:

All systems are within normal limits.

ENT Examination :-

Examination of ear:

	Right	left.
Pinna	normal	normal.
Preauricular region.	normal	normal.
Post auricular region	normal	normal.
External auditory canal.	normal	normal
Tympanic membrane	central perforation involving antero-inferior and postero inferior quadrant with edges smooth.	central perforation with antero inferior and postero inferior quadrant with edges smooth.

middle ear mucosa	normal	normal.
Tragal tenderness. } Mastoid tenderness }	Absent	Absent.

Functional examination :-

	Right	left.
Rinne's test	negative	negative.
weber's test		lateralized to left.
ABC	Same as that of examiner.	same as that of examiner.
Fistula test.	negative	negative.
Facial nerve.	normal	normal.
Field test	normal.	normal
Nystagmus	Absent	Absent.

Examination of nose and Paranasal sinuses.

External nose – normal, no scar & dilated veins.

Osteo cartilaginous framework and skin. } normal.

Vestibule, Ala, Columella

Anterior rhinoscopy :-

	Right	left.
Nasal passage. Septum. Floor of nose. lateral wall. }	normal	normal.
Roof	not seen	not seen.
Posterior rhinoscopy	not done.	not done.

Functional examination :-

	Right	Left
Cold spatula test	normal	normal.
Smell	normal	normal.

Cottles sign - negative.

No sinus tenderness elicited.

Examination of oral cavity and throat :-

Lip, gums, teeth :- normal.

gingivolabial sulcus :- normal.

Tongue, floor of mouth :- normal.

buccal mucosa :- normal.

Palate :- normal.

Tonsil and pillar :- normal.

Posterior pharyngeal wall :- normal.

Examination of neck :

On inspection the trachea appears to be central, no scars & dilated vein.

On palpation trachea is central, laryngeal crepitus present. No palpable lymph nodes.

SUMMARY

49 year old female patient presented with history of pain in right ear for past 2 years which progressed to left ear with decreased hearing and complaints of ear discharge. On examination she had BP of 140/90 mm Hg. On local examination there is bilateral central perforation in Tympanic membrane. On functional examination Rinne test is

negative on both ears and weber's test is lateralized to left ear.

Diagnosis

Case of Chronic suppurative otitis media, which is tubutympanic type, active, affecting both ear with conductive hearing loss more on the left side.

Case : 4

Name :- Anthony James.

Age/sex :- 16/M.

Place : Chennellur.

Chief presenting complaint :-

Nasal blocle X 6 months.
in right side.

History of presenting illness :-

Patient was apparantly asymptomatic 6 months back. Now he presented with right sideel nasal block for last 6 months. It was gradual in onset, non progressive - Increased nasal congestion during cold climate and there is no postural & diurnal Variation. No nasal discharge, no pain, no headache, no h/o foreign body insertion, no bleeding, no h/o allergy, No h/o any trauma, no loss of smell, no sore throat.

Past history.

No similar complaints in the past.
No h/o asthma.

Family history.

No relevent family history.

Personal history

Mixed diet, Sleep : nl, Appetite - nl,
Bowel and bladder habits : nl.
No known drug allergies.

General examination

Moderately built & nourished.
No pallor, icterus, cyanosis, clubbing & lymphadenopathy
Edema - nil.
Vitals: stable, On systemic Exn: all systems appear to be normal.

ENT examination

Examination of Nose & PNS.

- External osseocartilaginous framework :- normal.
- Ala, vestibule, columella :- normal,
- Anterior rhinoscopy :-

	Rt	Lt.
Nasal passage	narrow	normal.
Septum.	Deviate to Rt. (C-shaped deformity).	
Floor of nose	nl	nl.
	no discharge seen.	
Lateral wall.	Inferior turbinate seen.	Hypertrophied inf: turbinate.
Roof	not seen	not seen.
Posterior rhinoscopy	not done	not done

Functional examination :-

cold spatula test :- Reduced mist on Rt side.

Rt	Lt
+ve	Negative.

cottle's test

Examination of PNS

- Skin over the PNS looks normal.
- No tenderness elicited over frontal sinus, maxillary, ethmoidal sinus.

Examination of ear

	Rt	Lt
Pinna	Nl	Nl.
Preauricular region	nl	nl
Post auricular region	nl	nl.
External auditory canal	nl no discharge seen.	nl.
Tympanic membrane	nl	nl.
Tragal tenderness	nil	nil.
Mastoid tenderness	nil	nil.

Examination of Cranial nerve

Facial nerve :- Intact.

Examination of oral cavity and throat :-

Lip : nl.
Gum & teeth. : nl.
Gingivolabial sulcus :- nl.
Buccal mucosa :- nl.
Tongue & floor of mouth : nl.
Palate : nl.
Tonsil & pillars : nl
Uvula : nl.
Posterior pharyngeal wall : nl.

Diagnosis :-

Right sided Deviated nasal septum which is 'C' shaped deformity

Case : 5

Name : Sree rudra.
Age : 4 years.
Sex : Female.
Address : Aluva.
Informent : Mother.

Chief presenting complaint :

Nasal obstruction for 6 months.
Mouth breathing for 6 months.
Nasal discharge for 2 weeks.

History of Presenting illness :

Patient was apparently normal 6 month back. Then she developed nasal obstruction. It was insidious in onset and gradually progressed. There is also history of mouth breathing since 6 months. Symptoms are aggravated by upper respiratory tract infection, and are relieved on medication. There is history of nasal discharge since 1 week which is profuse, mucoid and non foul smelling. Mother also gives history of snoring and nasal tone of speech.
No h/o foreignbody insertion, epistaxis, allergy, headache, earache, ear discharge.
No h/o trauma.

Past history :-

Similar history for past 6 months.
No h/o any other systemic illness.
No h/o previous surgeries.

Personal history :-

Mixed diet, sleep and apetite - normal.
Bowel and bladder habits : regular. No h/o any allergy

* Family history.

No relevent family history.

General examination

Moderately built and nourished.

co-operative.

No pallor, Icterus, cyanosis, clubbing, lymphadenopathy, edema.

Pulse - 81/min, regular in rhythm, normal in volume and character.

Vitals are stable.

Afebrile.

Systemic examination

All systems are within normal limits.

ENT Examination:

Examination of Nose and PNS :-

	Right	Left.
External nose.		
- Osseo cartilaginous framework	nl	nl
- Vestibule, Ala, columella	nl	nl.
- Anterior rhinoscopy.		
Nasal passage	nl	nl.
Septum	nl	nl.
Floor of nose	mucoid discharge	nl.
Lateral wall	Pale. turbinates & corresponding meatus - normal.	turbinates & corresponding meatus - normal.
Roof	Not seen	not seen
Posterior rhinoscopy.	not done	not done

Functional examination :-

	Right	Left.
Cold spatula test	Reduced fogging	nl.
Smell sensation	Nl	Nl.

* Cottle's sign. ⟶ negative ~~normal~~

* No sinus tenderness elicited.

Examination of oral cavity & throat :-

Lips, Gums normal.

teeth :- crowding of upper teeth.

Gingivolabial sulcus : normal.

Buccal mucosa :- normal

Palate :- normal.

Tonsils & pilars : normal.

Posterior pharyngeal wall - normal.

Indirect laryngoscopy :- Not done.

Examination of Neck :-

No palpable lymph nodes.

laryngeal framework :- normal.

laryngeal crepitus :- Present.

No scars, no pulsations.

Thyroid : normal.

Examination of ear :-

	Rt	Lt
Pinna	nl	nl
Pre-auricular area.	nl	nl
Post auricular region.	nl	nl.
External auditory canal & TM	nl	nl.
Tragal & mastoid tenderness.	Absent	Absent.

Functional examination :-

	Rt	Lt.
Rinne's test	Positive	Positive
Weber's test	Equally heared on both sides.	
ABC test	Same as that of examiner.	
Fistula test.	Negative	negative.

Facial neuve :- Intact and normal.

Visual field :- normal.

SUMMARY :-

A year old female child presented with nasal obstruction and mouth breathing for past 6 months, and nasal discharge for past 1 week. On examination vitals stable, floor of right nose contain mucoid, non foul smelling discharge and floor was pale also. On cold spatula test. there is reduced fogging on right side there is crowding of upper teeth.

Diagnosis :-

Most probably adenoid hypertrophy.

Case : 6

Kumari, 20/F
Alappuzha.
Student.

Chief presenting complaint :

Bleeding from left nasal cavity for 5 months.

History of presenting illness :

Patient was apparently normal 5 months, before, then she developed bleeding from nose. It was from left nasal cavity. It was sudden in onset and severe. It occured 3-4 times a day with approximate amount 3 ml. It was fresh blood and does not contain any blood clots. The bleeding aggravates by headache and get releived by lying down. There is also associated giddiness tinnitus at the time of bleeding.

She also complaints of redness and watering from eyes during headache. She consulted a doctor and saied to have deviation of nose and given medications and adviced surgery.

No h/o trauma, nasal obstruction, nasal discharge loss of smell and facial pain or change in voice. No h/o excessive loss of weight or apetite. No h/o bleeding from other orifices, mucosa or hemorrhages rashes over body. No ear ache, ear discharge or any drug intake.

Past history :-

N/o similar history in the past.
H/o sinusitis relieved by medications.
N/o h/o DM, HTN, dyslipidemia, TB or any systemic illness.

Personal history :-

Mixed diet, no allergies / addictions.
Sleep and apetite : normal.
Bowel and bladder : regular.

Family history :-

No relevent family history.

General Examination

Conscious and co-operative.
Moderately built and nourished.
Pallor present.
No icterus, cyanosis, clubbing, lymphadenopathy or edema.
Pulse rate : 72/min, normal in volume, character, rhythm.
BP : 120/80 mm Hg Right arm sitting position.
Afebrile.

ENT Examination :-

Examination of nose and PNS :-

External osseocartilaginous frame work : nl.
Vestibule, Ala, columella :- normal.
Cottle's test :- negative.

Anterior rhinoscopy :-

	Rt	Lt
Nasal passage	nl	nl.
Septum.	Deviated to left.	Deviated, a projection present from septum congested.
Floor of nose.	normal	normal

Lateral wall	Hypertrophic turbinate pale in colour meatus normal no discharge seen.	Inferior turbinate congested. middle turbinate not seen meatus normal. No discharge seen.
Roof	not seen	not seen.
Posterior rhinoscopy	not done	not done.

Functional examination of Nose :-

	Rt	Lt
Cold spatula test	nl	reduced fogging
Sense of smell	nl	nl.

Examination of PNS :-

- Tenderness elicited over supra orbital ridge.
- No other sinus tenderness elicited.

Examination of ear :-

	Rt	Lt.
Pinna	nl	nl.
Pre-auricular region	nl	nl.
Ext. auditory canal	nl	nl.
TM	nl	nl.
Tragal & Mastoid tenderness	Nb	Nb.

Functional examination :-

Tuning fork test : normal.
Fistula test : negative.
Facial nerve : normal.
Visual field : normal.

Examination of Oral cavity and throat :-

Lips :- nl.

Teeth and gums :- nl.

Gingivo labial sulcus :- nl.

Buccal mucosa & palate :- nl.

Tongue & floor of mouth :- nl.

Tonsil and pillars : normal

Posterior phayngeal wall : normal.

Examination of Neck :-

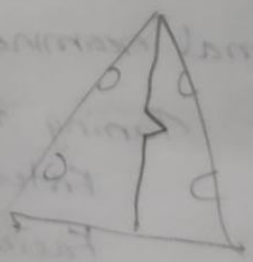
No enlarged lymphnodes.

SUMMARY :-

20 year old female patient who is known case of sinusitis come with complaints of bleeding from nose. It was sudden in onset, profuse and severe. O/E Vitals are stable, pallor present. on local examination, there is a deviation of nasal septum towards left from which a projection arises into nasal cavity. Septum and inferior turbinate congested on left side. There is reduced fogging on left side on cold spatula test.

Diagnosis :-

Deviated nasal septum with spur presenting as epistaxis sinusitis.



Case : 7.

Name : Reshma.
20 / F
Adress : Thrissur

Chief presenting complaints :-

Throat pain for 8 days.
Nasal obstruction for 8 days.
Burning sensation on swallowing ~~on swallow~~ for 8 days.

History of present illness :-

Patient was apparently normal 8 days back. Then she started excessive throat pain and nasal obstruction and came casuality on 9/9/22 and was admitted. Throat pain was acute in onset, gradually progressed aggravated on drinking cold waters. Throat pain was associated with fever and earache.
Nasal obstruction was acute in onset and gradual in progression. tiredness present.

Past history of patient :

No h/o similar complaints in the past.
h/o earache 2 months ago ; took medication for the same.
No h/o TB, pneumonia, syphilis, asthma etc.
No DM, HTN, dislipedemia.
Hystory of appendicitis.

Personal history

Mixed diet, sleep and apetite normal.
Bowel and bladder movement :- normal.

family history :

No relevent family history.

General examination.

Cooperative and well oriented for time, place & person.
Well built and nourished.
No pallor, icterus, cyanosis, clubbing, edema.
Enlargement of lymphnode present.
skin and hair normal.

Systemic examination.

All systems are within normal limits.

Examination of oral cavity

Lips, Buccal mucosa :- normal.
gums and teeth :- normal gums.
Dental caries found.
Hard palate :- normal.
Tongue :- normal size, no deviation on protrusion, no ulcerations.
Floor of mouth normal.

Examination of oropharynx

- Tonsil present.
- B/L enlargement of tonsil.
- Simmetrical, b/l, large.
- Crypts :- White crypts present.
- Bulging present.
- Pillars :- congestion of pillars seen, tonsil and pharyngeal mucosa seen.
- Soft palate :- slight redness.
- Posterior pharyngeal wall congestion.

Examination of Nose

External osseo-cartilaginous framework, skin ± normal.
columella, ala, vestibule :- Normal.

Anterior rhinoscopy :-

	Rt	Lt.
Nasal passage	wide	narrow
Septum		Deviated to left.
Floor of nose	normal	nl.
Roof	not seen	not seen.
Lateral wall	enlarged turbinates	nl.

Posterior rhinoscopy — not done.

Functional examination of nose :-

Cold spatula test : reduced fogging on Left.
Cottle's test : negative on (R)
positive on (L).

Ex of PNS :-

no sinus tenderness elicited.

Examination of ear :-

	Rt	Lt.
Pinna.		
Preauricular region.	nl	nl
Post auricular region.		
EAC, TM.		
Tragal + Mastoid tenderness.	Ab	Ab.
Facial nerve.	nl	nl.
Field of Vision.		
Nystagmus.	Ab	Ab.

Functional examination of ear :-

	Rt	Lt
Rinne's test :	Positive	Positive.
Weber test	Central	Central.
ABC	nl	nl.

Examination of neck.

Inspection :- No dilated vein, no scarring.

Palpation :- No tenderness, pulsation ~~present~~ present.
Enlargment of jugulodigastric LN present.

SUMMARY

20 y/o female, with no comorbidities presented with complaints of throat pain and left nasal obstruction since 8 days.
O/E enlarged tonsil with white crypts and congestion seen. Nasal septum deviated to left side and hypertrophied turbinate in right side.

Diagnosis

Resolving acute tonsillitis and DNS to left.

Case : 8

Jagan , 19 y/M , Thrippunithara , Student.

Chief presenting complaint :-

Bilateral nasal obstruction for 2 weeks.

History of presenting illness :-

Patient a known case of allergy since 10 year of age , developed loss of smell 2 months back , insidious in onset , progressed , ~~and later~~ ad later relieved on taking medication.

He also had complaints of change in voice since one month. He had nasal obstruction , gradual in onset , progressed, aggravated at night. Nasal obstruction is associated with ~~nasal obstruction~~ breathlessness.

He had. H/o snoring , headache and facial pain.

No H/o sneezing , epistaxis , wheezing , dental infection / caries tooth.

Past history :-

H/o allergy to dust.

N/o similar history in past.

N/o H/o DM , HTN , dyslipidemia , TB or any systemic illness.

Family history.

N/o relevent family history.

Personal history :-

Mixed diet , dust allergy , no addictions and substance dependence sleep & apetite normal. B & B regular.

General examination

- Conscious , oriented and cooperative.
- Moderately built and nourished.
- NO pallor , icterus , cyanosis , clubbing , lymphadenopathy
- Vitals :- stable

Systemic examination :-

All systems appear normal.

ENT Examination

Examination of nose and PNS :-

External osteocartilaginous framework : nad.

Vestibule, Ala, Columella :- nl.

~~Cottle's test :- negative~~

Anterior rhinoscopy :-

	Rt	Lt
Nasal passage	no discharge.	no discharge.
Septum.	Posteriorly deviated to Rt & anteriorly deviated to Lt.	
Floor of nose	Nl	Nl.
Lateral wall.	Hypertrophic inferior turbinate. Pale in colour. meatus normal. no discharge seen.	nl.
Roof	not seen	not seen.

Posterior rhinoscopy — not done — not done.

Functional examination of nose :-

Cold spatula test	nl	nl.
Sense of smell.	~~nl not done~~	~~nl not done~~
Cottle's test	negative	negative

Examination of PNS :-

Inspection :- Skin over sinus appears normal.

Palpation :- no sinus tenderness elicited.

Examination of ear :-

	Rt.	Lt.
Pinna.		
Pre-auricular region.	nl.	nl.
Post-auricular region.		
EAC & TM.		
Tragal & mastoid tenderness.	Ab	Ab.

Functional examination :-

Tuning fork test :-

Rinnes test	Positive	Positive
Weber test.	centralized	centralized
ABC	same as that of examiner.	
Fistula test	negative.	negative.
Facial nerve	nl.	
Visual field	nl	

Examination of oral cavity & throat.

Lips :- nl.
Teeth and gums :- nl
Gingivo-labial sulcus :- nl.
Buccal mucosa & palate :- nl.
Tongue & floor of mouth :- nl.
Tonsil and pillar : nl.
Post. pharyngeal wall :- congested.

Examination of Neck :-

Inspection :- No visible scars, sinuses, dilated vein, pulsation, swelling, neck movements :- ↑ movements with respiration and deglutition nl.

Palpation :-

No local rise of temp.
No palpable LN.
laryngeal crepitus present.

SUMMARY :-

19 y/male known case of allergy presented with complaints of nasal obstruction for past 2 weeks associated with breathlessness, change in voice, snoring, loss of smell with no other comorbidities.

O/E.

Deviated nasal septum :- Posteriorly deviated to Rt and anteriorly to left. Bilateral hypertrophy of inferior turbinates, congestion of post. pharyngeal wall.

Diagnosis :-

Deviated nasal septum :- 'S'-shaped deformity.

Case : 9

Soudeadi , 57/F, Mattanchery

CPC :-

Discharge from both ear for 3 days.
Itching both ear for 3 days.

HOPI :-

Patient was apparently normal One week back, then she developed itching sensation ad aural fullness on both ears. After 3 day ~~she~~ ear discharge start flowing for both ears. Discharge was yellow in color on right ear and brown colored on left ear of mucopurulent nature. At first the discharge was watery type later changed to mucopurulent type. She also had severe itching on both ears during discharge. After discharge she will be relieved of the aural fullness. She also c/o occasional tinnitus. No h/o pain, giddiness, swelling or headache, double vision, deviation of angle of face. No URTI, Allergies etc.

Past history :

She had similar episodes of itching, discharge from both ear since 5 years. This reduced on taking medications.
She had a history of ear discharge at 12 year of age in right ear.

Medical history

k/c/o Asthma x 8 years.
HTN x 5 yrs.
Hypothyroidism x 1 yrs
} taking medication for both.

Family history :-

No relevant family history

Personal history :-

Mixed diet.
Sleep, B & B : normal.

ENT Examination.

Examination of ear.

	Rt	Lt
Pinna & surrounding area.	nl	nl.
External auditory canal.	Scanty discharge on both side	
TM.	medium sized perforation seen margin regular mucosa congested, polyp no granulomas ~~seen~~ Ossicles not seen. rest of TM normal.	medium sized perforation. margins regular mucosa congested. no granuloma, polyp "
Mastoid.	No swelling, tenderness in both side. No obliteration of retroauricular region No tenderness "	
Eustachian tube	nl on valsalva	nl on valsalva.
Examination of facial nerve.	nl	nl.

Functional examination :-

	Rt	Lt.
1) Auditory function :-		
Rinne	⊖	⊖
Weber.	lateralized to Rt.	
ABL.	shortened	shortened.
2) Vestibular function.		
Spontaneous nystagmus	-ve	-ve.
Fistula test	-ve	-ve.

Examination of Nose & PNS :-

External nose :-

Skin, osseocartilaginous framework.
Ala, vestibule columella. } nl nl.

Anterior rhinoscopy :-

Nasal passage.
Septum.
Floor of nose.
Roof.
lateral wall. } nl nl.

Post. rhinoscopy. not done not done

Functional examination :-

Spatula test. -ve +ve
Sense of smell +ve +ve.

Examination of PNS :-

Sinus tenderness absent.

PNS : ⊖.

Examination of oral cavity & Pharynx :-

Lips, buccal mucosa, gum & teeth, hard palate.
floor of mouth, retromolar trigon :- nl.

Tonsil ad pillars :- nl in size ad plav.

Base of tongue ad valleculae :- nl.

Posterior pharyngeal wall : nl.

SUMMARY

A 57 yr/F came to OPD with c/o discharge, itching both ears for past 3 days, She also gave a previous history of episodes of discharge from both ears. Pt is k/c/o Asthma, HTN & hypothyroidism. OE scanty discharge (+) on both ears with medium sized perforation (central) seen in both TM.

Diagnosis

most probably a/c exacerbation of CSOM of tubotympanic type, active) in both ear.

Case : 10

Mariums Beevi 63/F Kalamassery, Housewife.

Chief Presenting complaints :-
Sneezing for 2 weeks
Left sided nasal obstruction for 2 week
~~Sneezing for 2 weeks.~~

HOPI :-

Patient was apparently normal 2 years back. Then she started excessive sneezing, which was aggravated when exposed to dust and relieved on taking medication. There is no diurnal or seasonal variations.

She also had left sided nasal obstruction for the past. Its insidious in onset, gradually progressed to present size. Aggravating on colder climate of No relieving factors. Associated with loss of smell - Bilateral.

No nasal discharge into postnasal drip. No epistaxis and no snoring, no change in voice.

Past history :-
No hlo similar complaints in the past

Medical history :-
No HLO DM, HTN., TB, pneumonia, Asthma etc.

Treatment history : Medicine taking for diabetes & HTN.

Family history :-
No relevent family history.

General examination :-
conscious, co-operative, moderately well built & nourished.
No icterus, cyanosis, pallor, clubbing, Lymphadenopathy.
Vitals are stable
On systemic examination : all systems within normal limit

ENT Examination :-

Examination of Nose :-

External nose :-

Skin, osteocartilaginous framework : nl.

Ala, vestibule, columella : normal.

Anterior rhinoscopy :-

	Rt	Lt.
Nasal passage	wide	narrow.
Septum.	Deviated to left	
Floor	nl	nl.
Roof	not seen	not seen.
Lateral wall.	Inferior turbinate seen.	Pink color polyp seen.

Posterior rhinoscopy : not done.

Functional examination of Nose :-

	Rt	Lt.
Cold spatula test	normal	reduced fogging.
Cottle's test	negative	positive.
Sense of smell.	Absent	Absent

Examination of PNS :-

- Ethmoidal sinus :- Tenderness elicited on both sides.
- No tenderness over maxillary and frontal sinus.

Examination of Ear :

	Rt	Lt.
Pinna.	nl	nl
Pre auricular		
Post auricular		
EAC, TM.		
Tragal, mastoid tenderness	Ab	Ab

Functional examination of ear :-

Tuning fork tests	Rt	Lt
Rinne	+ve	+ve.
Weber.	Central	Central.
ABC	Same as that of examinee.	
Facial nerve.	nl	nl.
Field of vision.	nl	nl.

Examination of Oral cavity

Lips
Teeth, gum, Buccal mucosa, Tongue, Tonsil & pillars, Uvula } nl.

Examination of Neck.

Inspection :- No dilated vein, No swelling, No pulsations.

Palpation :- No palpable lymph node, no pulsations present, no tenderness.

SUMMARY :

63 y/o Female presented with complaints of sneezing and left nasal obstruction since 2 years with known case of DM & HTN.

O/E nasal polyp seen on left side on nasal cavity, and septum is deviated to left side. & ethmoidal sinus tenderness is elicited.

Diagnosis :-

Bilateral ethmoidal polyp with left side deviated septum. (C-shaped).