

First ever book conceptualized for giving One Touch to ENT by
Flowcharts • Tables • MCQs • One-Liners



ONE Touch ENT



For NEET/NEXT/FMGE/INI-CET

Special Features

- Written and Compiled by a Leading Faculty and Subject Expert of ENT
- Enriched with Latest Updates up to July 2023
- Entire theory covered in just **190 pages** in Flowcharts, Tables and One-liners format
- **100+** MCQs of Recent Exams covered up to July 2023
- All important Illustrations/ Images covered



CBS Publishers & Distributors Pvt. Ltd.

Editor
Sachin Budhiraja

Manisha Sinha Budhiraja

ONE Touch ENT



For NEET/NEXT/FMGE/INI-CET

Manisha Sinha Budhiraja MBBS (LHMC, Delhi)
MS (ENT), Safdarjung Hospital
Delhi University
DNB (ENT)

Editor
Sachin Budhiraja MBBS (UCMS, Delhi)
MD (Medicine), Safdarjung Hospital
Delhi University

Dedicated to Education



CBS Publishers & Distributors Pvt Ltd

- New Delhi • Bengaluru • Chennai • Kochi • Kolkata • Lucknow • Mumbai
- Hyderabad • Jharkhand • Nagpur • Patna • Pune • Uttarakhand

Preface

Dear students,

ENT, an important subject in the MBBS curriculum is a high mark fetching subject. To score good, it is not only essential to understand the important topics, but also to be able to recall them when you need it the most. Yes, **Revision** is the key to success. So, **keep revising not only till you can get it right but till you can never get it wrong.**

One Touch ENT is an effort from my side which will enable the students to:

- Revise entire ENT quickly before exam
- Think clinically
- Know the approach to the diagnosis and treatment of the ENT diseases as asked in the current exams
- Answer all the questions including **clinical questions, fact-based questions as well as image-based questions with ease.**

The salient features of this book are:

- The entire subject has been covered in a very crisp manner with the help of flowcharts and high-yield tables to make the revision a cakewalk for students.
- Although the content is in the form of tables and flowcharts, a clinical approach has been maintained which will help the students in doing well in the current clinical-based exam pattern.
- All PYQs of NEET and INICET have been marked as PYQ next to it.
- All the clinical images that are important have been given alongside the text.

I have left no stone unturned in making this book student friendly and exam oriented, now it's your turn to utilize my efforts and convert it in your success.

Always remember that success is neither magical nor mysterious. Success is the natural consequence of your consistent hard work toward your goal with infinite patience, infinite enthusiasm and infinite passion till you reach your destination.

Dedicated to Education

“Take up one idea. Make that one idea your life. Think of it, dream of it, live on that idea. Let the brain, muscles, nerves, every part of your body, be full of that idea, and just leave every other idea alone — this is the way to success.”

— Swami Vivekananda

With lots of love!

Manisha Sinha Budhiraja

Contents

Preface	v
---------------	---

EAR

1. Embryology, Anatomy and Diseases of Pinna.....	3
2. Embryology and Anatomy of External Auditory Canal.....	5
3. Tympanic Membrane.....	8
4. Conditions of External Ear Presenting with Only Hearing Loss—No Pain/Discharge.....	10
5. Embryology and Anatomy of Middle Ear.....	11
6. Embryology and Anatomy of Mastoid.....	20
7. Acute Suppurative Otitis Media and Bullous Myringitis.....	22
8. Chronic Otitis Media (COM).....	23
9. Tubercular Otitis Media.....	27
10. Chronic Squamous Otitis Media.....	28
11. Complications of Otitis Media.....	32
12. Nerve Supply of Ear and Referred Otalgia.....	35
13. Stepwise Approach when Patient Presents with only Hearing Loss with Intact TM—No Pain/Discharge.....	36
14. Tuning Fork Test (TFT).....	37
15. Pure-Tone Audiometry (PTA).....	39
16. Impedance Audiometry (IA).....	44
17. OTO Acoustic Emissions (OAES) or “Kemp” Echoes.....	46
18. Brainstem Evoked Response Audiometry/Auditory Brainstem Response (BERA/ABR).....	47
19. Otitis Media with Effusion (OME)/Serous Otitis Media (SOM)/Glue Ear.....	48
20. Otosclerosis.....	49
21. Glomus Tympanicum/Jugulare.....	51
22. Noise Induced HL (NIHL), Ototoxicity, Presbycusis.....	52
23. Sudden SNHL (Otologic Emergency).....	54
24. Pediatric Hearing Assessment.....	54
25. Cochlear Implant.....	58
26. Acoustic Neuroma/Vestibular Schwannoma.....	59
27. Physiology of Vestibular System.....	65

NOSE

1. Anatomy of External Nose and Anatomy of Septum.....	75
2. Fractures of Nasal Bone.....	80
3. Nerve Supply of Nose and its Anesthesia.....	81
4. Anesthesia of Nose.....	82

5. CSF Rhinorrhea	83
6. Important Facial Fractures.....	84
7. T Cell Lymphoma	87
8. Allergic Rhinitis and Vasomotor Rhinitis.....	88
9. Rhinitis Medica Mentosa	89
10. Anatomy of Lateral Wall of Nose.....	89
11. Anatomy of Paranasal Sinuses.....	91
12. Acute Rhinosinusitis.....	94
13. Chronic Rhinosinusitis	96
14. Complications of Sinusitis.....	100
15. Chronic Rhinosinusitis with Nasal Polyps (CRSwNP).....	102
16. Rhinosporidiosis, Inverted Papilloma and Carcinoma PNS.....	106
17. Angiofibroma.....	108
18. Some Other Important Tumors/Benign Conditions of Nose and PNS	109
19. Arterial Supply of Nose and Epistaxis	110

PHARYNX

1. Anatomy of Nasopharynx.....	115
2. Adenoid Hypertrophy	117
3. Nasopharyngeal Carcinoma.....	119
4. Anatomy of Oropharynx.....	120
5. Approach and D/D of Infections of Pharynx	121
6. Tonsils.....	125
7. Tonsillectomy.....	126
8. Peritonsillar Abscess/Quinsy.....	129
9. Ludwig's Angina.....	130
10. Parapharyngeal Space/Lateral Pharyngeal/ Pharyngomaxillary Space Anatomy and Abscess.....	131
11. Retropharyngeal Space/Space of Gillette	134
12. Zenker's Diverticulum.....	135
13. Pharyngeal Wall.....	136
14. Motor Nerve Supply of Pharynx	136
15. Anatomy of Oropharynx.....	137
16. Nerve Supply of Tongue	138
17. Oral and Oropharyngeal Cancers.....	138
18. Oral Cavity Carcinoma.....	140

LARYNX

1. Anatomy of Larynx	143
2. Muscles of Larynx.....	147
3. Methods of Examining the Larynx.....	150
4. Conditions of Larynx Presenting with Hoarseness	151

5. Carcinoma Larynx—TNM Staging and Management.....	154
6. Neck Dissection in Carcinoma Larynx.....	155
7. Rehabilitation Following Laryngectomy.....	156
8. Functional Disorders of Voice.....	157
9. Nerve Supply of Larynx and Vocal Cord Palsy.....	158
10. Stridor in Children—Congenital Causes	160
11. Foreign Body Larynx.....	162
12. Tracheostomy.....	164
13. Acute Infections of Larynx.....	166
14. TB Larynx.....	168

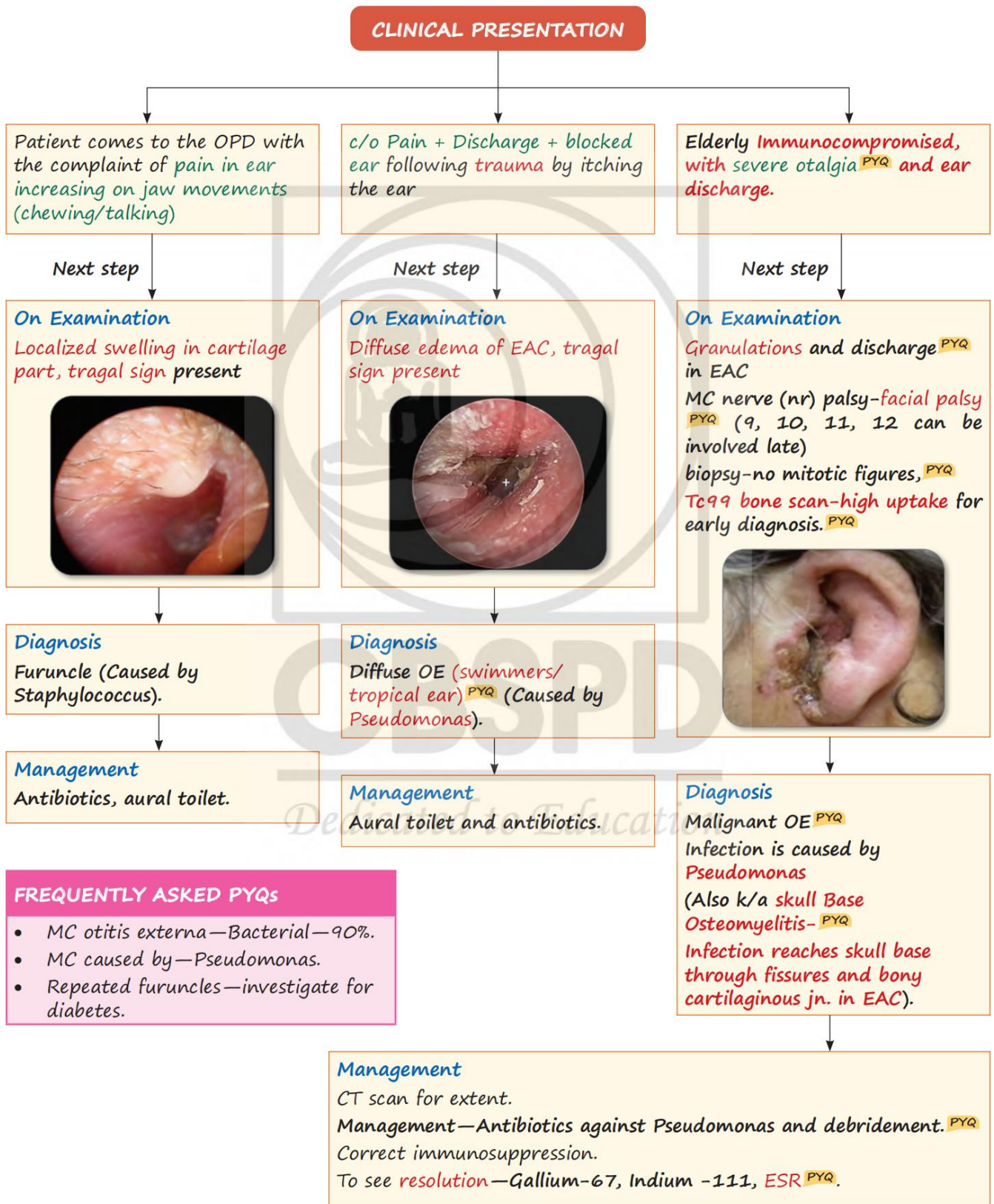
LATEST QUESTION PAPERS

NEET PG 2023	171
NEET PG 2022	172
NEET PG 2021	174
INI-CET May 2023.....	176
INI-CET November 2022	178
INI-CET May 2022.....	179
INI-CET October 2021.....	181
FMGE July–January 2023.....	183
FMGE June 2022	185
FMGE June 2021	188

CBSPD

Dedicated to Education

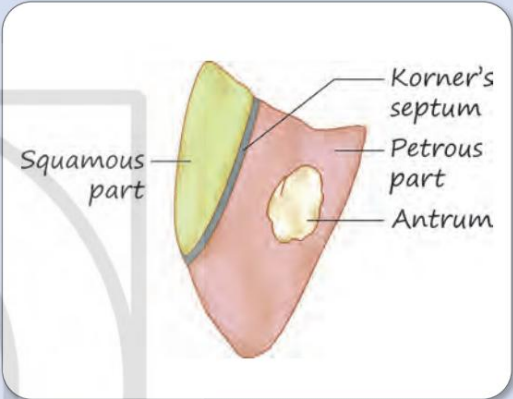
APPROACH TO DIAGNOSIS AND MANAGEMENT OF IMPORTANT CONDITIONS OF EXTERNAL AUDITORY CANAL PRESENTING WITH PAIN/EAR DISCHARGE



6. EMBRYOLOGY AND ANATOMY OF MASTOID

IMPORTANT POINTS ON THE DEVELOPMENT OF MASTOID

Part of EAR	Develops from	Developmental anomaly/ Developmental significance
Mastoid	Petrous and squamous part of temporal bone. PYQ Mastoid air cells except mastoid antrum PYQ (completely developed at birth) continue to develop till 18 years of age. Mastoid tip develops at 2 years. PYQ	Persistent petrosquamosal suture k/a Korner's septum PYQ can be present leading to incomplete clearance of disease from mastoid antrum during surgery. Mastoid tip develops at 2 years of age so facial nerve not protected before that. Postaural incision before 2 years should be superior and horizontal to protect facial nerve PYQ .



Korner's septum (Petrosquamosal suture)

FREQUENTLY ASKED PYQs

Completely developed at birth

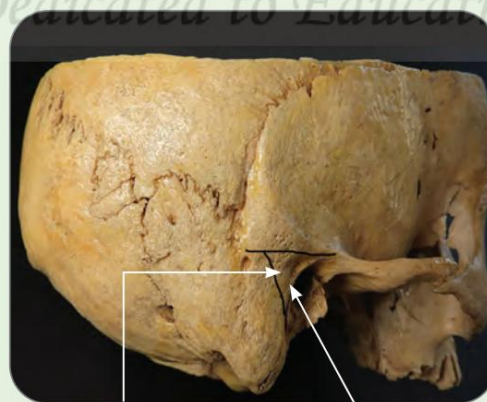
- Middle Ear, Inner Ear—Organ of Corti, Mastoid antrum

Not completely developed at birth

- Mastoid tip, EAC—bony part

IMAGE-BASED PYQ

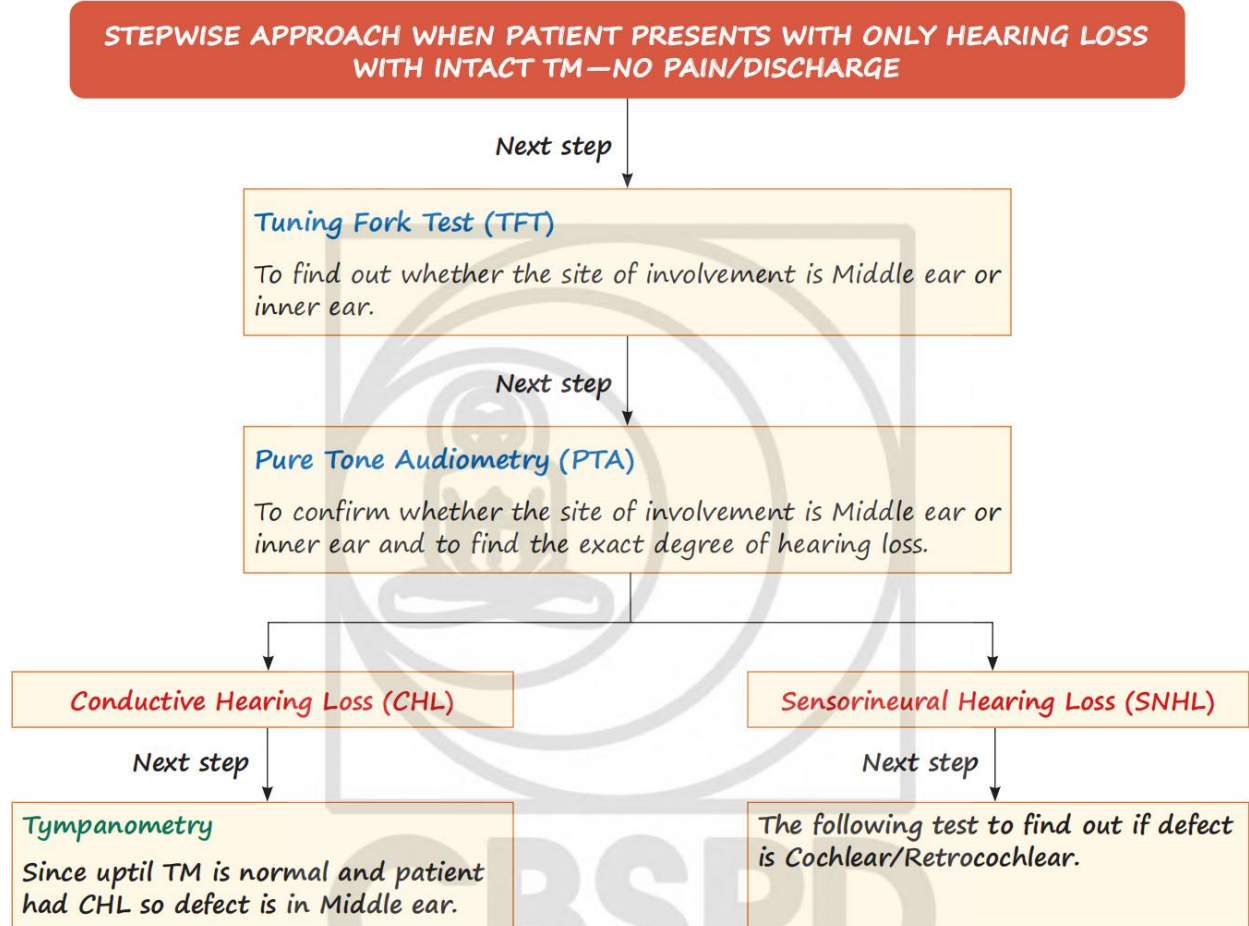
Identify.



MacEwen's/
Suprameatal triangle

Spine of
Henle

13. STEPWISE APPROACH WHEN PATIENT PRESENTS WITH ONLY HEARING LOSS WITH INTACT TM—NO PAIN/DISCHARGE



Test	Cochlear pathology	Retrocochlear pathology
Recruitment, i.e. abnormal growth of loudness (ABLB test)	Present	Absent
SISI score, i.e., ability to identify short increments (1 dB) of sound	70–100%	0–20%
Acoustic reflex threshold	Decreased due to recruitment	Increased
Tone decay (nerve fatigue)	Absent	Present
Acoustic reflex decay (nerve fatigue)	Absent	Present
OAEs	Absent	Present
BERA (best test)	Delayed wave I, but remaining waves normal	Only wave I is present, rest are absent or affected
Speech discrimination score (SDS) or word discrimination score	Reduced. Rollover phenomenon absent	Very poor. Rollover phenomenon present

16. IMPEDANCE AUDIOMETRY (IA)

Components of IA and its Use

Impedance Audiometry consists of →
Tympanometry + Stapedial reflex. PYQ

Use → To find the condition of ME if TM is intact and the patient has CHL. PYQ



Tympanometer

When to do Tympanometry

When patient presents with **Only Hearing Loss** with intact TM— **no pain/ discharge** and test shows **CHL** (TFT—bc>ac, Weber's—same side, PTA— AB gap + BC normal) indicating the defect to be in the middle ear.

Next Step ↓

Tympanometry to rule out and find out the defect in middle ear, e.g., **SOM, Ossicular discontinuity, otosclerosis.**

ALL YOU NEED TO KNOW ABOUT TYMPANOMETRY

Important PYQs to remember about Tympanometry

- It is an Objective test. PYQ
- Frequency of tone given by probe in adults – **226 or 220 Hz** PYQ
- Tympanometry measures **compliance (TM mobility) and Middle ear pressure (ET function)** PYQ
- It is the Best investigation for Eustachian tube function. PYQ

Also know:

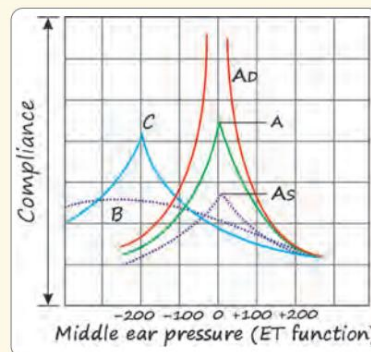
Other tests for Eustachian tube function.

Valsalva, Politzer, Toynbee, Frenzel, ET Catheterization

Result and interpretation of Tympanometry

Diagnosis based on Tympanometry graph

Type of Tympanogram	Finding	Interpretation/Diagnosis
A	Normal compliance and normal ME pr	Normal ear
As	Reduced compliance with normal ME pr	Otosclerosis/ Tympanosclerosis PYQ
Ad	Increased compliance with normal ME pr	Ossicular Discontinuity PYQ
B/Dome	reduced compliance and negative ME pr	Serous Otitis Media PYQ
C	normal compliance and negative ME pr	Early ET obstruction PYQ
Flat	No curve	TM perforation, fluid completely filling middle ear PYQ



Tympanometry graph

19. OTITIS MEDIA WITH EFFUSION (OME)/SEROUS OTITIS MEDIA (SOM)/GLUE EAR

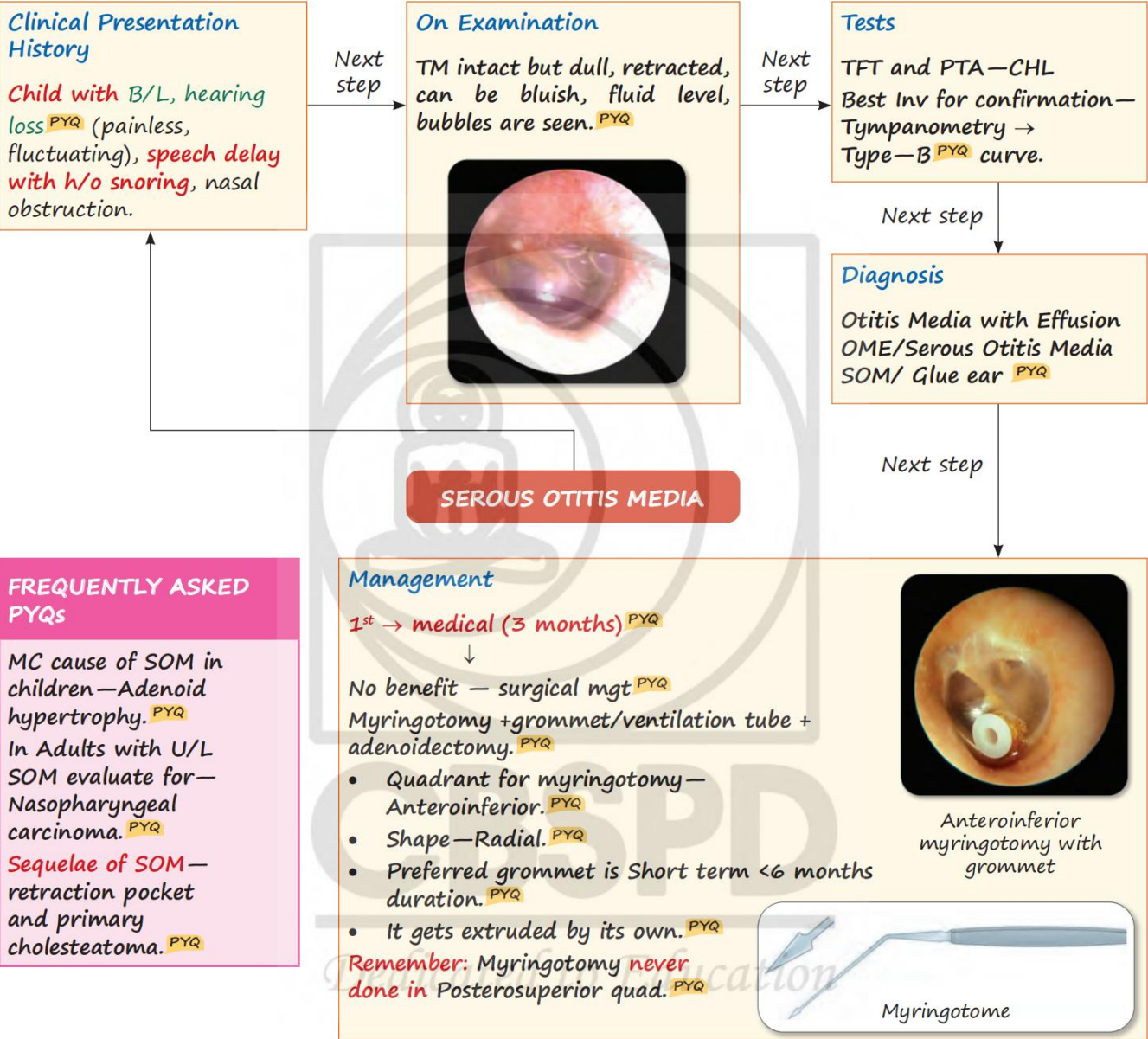


IMAGE-BASED PYQs

Identify.



Ans. 1. SOM, 2. Grommet in AI quad, 3. Myringotome

27. PHYSIOLOGY OF VESTIBULAR SYSTEM

THINGS TO KNOW ABOUT NYSTAGMUS OF PERIPHERAL ORIGIN IN A PATIENT OF VERTIGO

Differences between Peripheral and Central Nystagmus

	Peripheral nystagmus	Central nystagmus
Latency ^{PYQ}	Present ^{PYQ}	Absent ^{PYQ}
Duration ^{PYQ}	Limited (1.5 min-2min) ^{PYQ}	Not Limited ^{PYQ}
Fatigability	Present	Absent
Direction ^{PYQ}	Fixed ^{PYQ}	Changing ^{PYQ}
Optic fixation ^{PYQ}	Nystagmus disappears ^{PYQ}	Nystagmus does NOT disappear ^{PYQ}
Torsion with horizontal/vertical ^{PYQ}	Present ^{PYQ}	Pure horizontal/Pure Vertical/Pure torsional ^{PYQ}



Frenzel goggles—to remove optic fixation and magnify patient's eyes

NYSTAGMUS

Nystagmus Type in Different Conditions of Inner Ear

Due to involvement of	Type of Peripheral origin Nystagmus seen	Seen in which conditions
Vertical canal (PSC, SSC) ^{PYQ}	Vertical nystagmus with Torsion. ^{PYQ}	Posterior and superior canal BPPV, Superior SCC dehiscence.
Horizontal SCC ^{PYQ}	Horizontal nystagmus ^{PYQ}	Horizontal SCC, BPPV.
Complete involvement of labyrinth (hypo-active) ^{PYQ}	Horizontal nystagmus with Torsion. ^{PYQ}	Vestibular neuritis (Complete destruction of vestibular nerve) ^{PYQ} , purulent labyrinthitis, late stages of Meniere's.

Direction of Peripheral Origin Nystagmus

Direction of Nystagmus is—direction of fast component ^{PYQ}—fixed—toward more active side

Type of lesion	Seen in which condition	Direction of nystagmus
Hyperactive lesion of labyrinth ^{PYQ}	BPPV ^{PYQ}	Toward more active side → i.e., Toward the involved ear. ^{PYQ}
Hypoactive lesion of labyrinth ^{PYQ}	Vestibular neuritis, purulent labyrinthitis. ^{PYQ}	Toward more active side → i.e., Toward the normal ear. ^{PYQ}

For example:

- In right PSC BPPV—vertical nystagmus toward right.
- Right vestibular neuritis—Horizontal nystagmus to left (active) side.

Q. A patient is found to have acute vertigo and horizontal nystagmus with the slow component toward the left. In which of the following conditions would you see this finding?

- A. Posterior canal BPPV
- B. Superior canal BPPV
- C. Right hypoactive labyrinth
- D. Left hypoactive labyrinth

Ans: D. Left hypoactive labyrinth

11. ANATOMY OF PARANASAL SINUSES

PYQs ON FRONTAL SINUS

- Absent at birth.
- Last to completely develop.
- Last to be seen on X-ray.
- Superiormost sinus.
- Opens in middle meatus.

PYQs ON MAXILLARY SINUS

- Most pneumatized at birth.
- Largest.
- Also K/a Antrum of Highmore.
- Shape of maxillary sinus—pyramidal; base—lateral wall of nose.
- Apex—toward zygoma.
- Floor related to 2nd premolar and 1st molar (extraction can lead to oroantral fistula).

PARANASAL SINUSES

Nose as well as all sinuses lined by respiratory epithelium i.e., ciliated columnar epithelium like nasal cavity. ^{PYQ}

PYQs ON ANTERIOR ETHMOIDS

Opens in middle meatus
anterior ethmoidal cells are as follows:

- **Bulla ethmoidalis** → Most prominent.
- **Agger nasi** → Anterior most.
- **Haller's cells** → In relation to floor of orbit (Infraorbital)/ roof of max sinus.

PYQs ON POSTERIOR ETHMOIDS

- Open in—superior meatus
- Posterior ethmoidal Cell—**Onodi Cell**.
- Onodi cell is in relation to sphenoid sinus.

And is closely related to

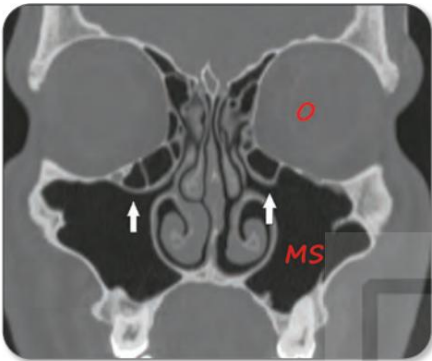
- Optic nerve and
- ICA.

PYQs ON SPHENOID SINUS

- Present in—body of sphenoid.
- Drains in—sphenoethmoidal recess.
- Related to—optic nerve and Pituitary—related to superior wall; ICA related to lateral wall.
- Most common Sphenoid sinus Pneumatization—sellar (pneumatization below and posterior to sella turcica).

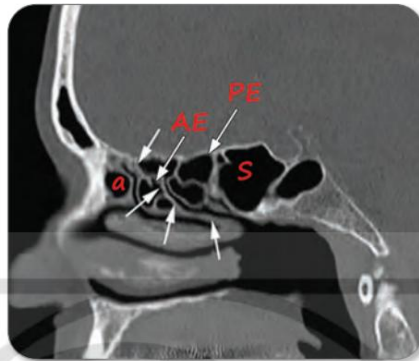
Dedicated to Education

IMPORTANT CT IMAGES OF PARANASAL SINUSES PYQ



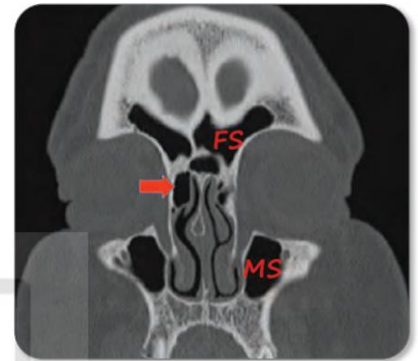
CT—coronal cut arrow showing Haller cell

O — Orbit
MS — Maxillary sinus



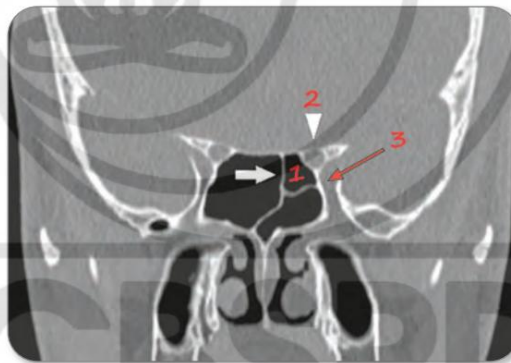
CT—Sagittal cut—agger nasi (a)

Arrow showing:
AE — Anterior ethmoid
PE — Posterior ethmoid
S — Sphenoid sinus



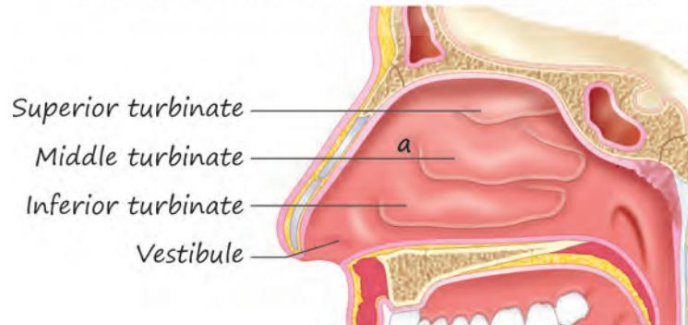
CT—coronal cut arrow showing agger nasi

FS — Frontal sinus
MS — Maxillary sinus





CT—coronal cut: 1. Onodi cell, 2. Optic nerve, 3. Internal Carotid artery

Dedicated to Education



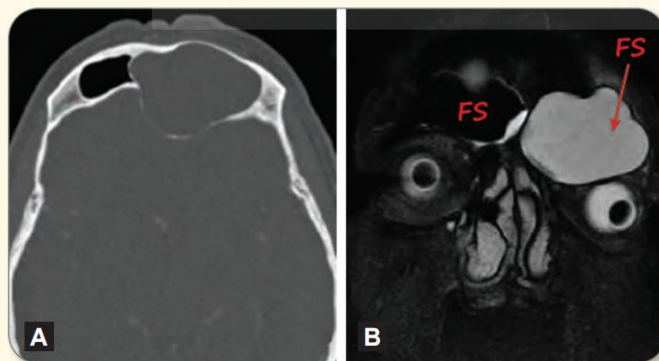
Agger nasi (a) cell PYQ

IMPORTANT DIFFERENCES BETWEEN ORBITAL COMPLICATIONS AND CAVERNOUS SINUS THROMBOSIS

Orbital cellulitis	Cavernous sinus thrombosis
Presents with gradual onset of unilateral—eyelid edema, conjunctival chemosis, proptosis, restricted ocular movements, ophthalmoplegia. PYQ	Abrupt onset of fever with associated chills and rigor. PYQ
Ophthalmoplegia (3, 4, 6 together)	First nerve involved is 6th. PYQ Then 3, 4.
Unilateral	Unilateral chemosis, proptosis, restricted ocular movements progresses to B/L involvement. PYQ
Absent	Trigeminal paresthesia + nt
	
Orbital cellulitis of left eye	Cavernous sinus thrombosis— B/L

CHRONIC COMPLICATIONS OF SINUSITIS

- Mucocele **PYQ** → Cystic swelling in the superomedial quadrant of orbit pushing orbit downward, forward (nonaxial proptosis), laterally
- MC seen in → Frontal sinus **PYQ**



Mucocele of Frontal Sinus (FS) → can also follow trauma (iatrogenic, e.g., FESS or noniatrogenic leading to stenosis obstruction of frontal sinus drainage.)

Pyocele
Due to secondary infection of mucocele.

MANAGEMENT OF NASAL POLYPS

Surgical

- In Allergic Fungal Sinusitis (AFS) and AC polyp the first line of management is FESS. ^{PYQ}
- Postoperative oral and local steroids are given in AFS. ^{PYQ}
- No role of steroids in AC polyp. ^{PYQ}

Medical

- In rest the first line of management is medical with topical steroids, saline nasal spray and management of the underlying systemic condition. ^{PYQ}
- If not benefitting → FESS. ^{PYQ}

Note

Chances of recurrence of nasal polyps which follow systemic condition is very high. In recurrent nasal polyps management remains same.

CONDITIONS WHICH MIMIC POLYP/LOOKS LIKE POLYP

CONDITIONS WHICH MIMIC POLYP /LOOKS LIKE POLYP ^{PYQ}

In elderly

- **Inverted papilloma/ carcinoma.** ^{PYQ}
- * Any elderly with elderly—Nasal obstruction +blood tinged nasal discharge with polypoidal mass from middle meatal area, biopsy should be taken to rule out tumor ^{PYQ}.

In a child

- **Meningoencephalocele** ^{PYQ}
- * Polypoidal compressible, transilluminant, mass in the nostril of an infant.
- * Furstenberg test +ve.

All age groups

- **Concha bullosa** ^{PYQ} — It is pneumatized turbinate (MC seen in middle turbinate ^{PYQ}).
 - * **Probe test** ^{PYQ} is done to differentiate it from polyp— A turbinate bleeds and pains on probing but a polyp does not bleed or pain on probing ^{PYQ}.
- A probe can be passed all around a polyp but not all around turbinate.



CT showing B/L concha bullosa of middle turbinate ^{PYQ} (*)



Endoscopic appearance of polyp ^{PYQ}



Concha bullosa

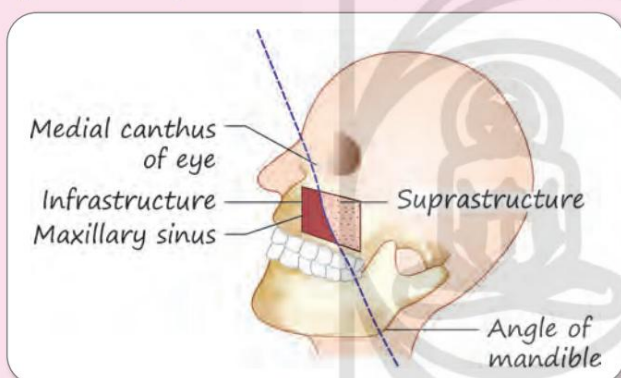
IMPORTANT PYQs ON TUMORS OF NOSE

Ohngren's line: Imaginary line passing from medial canthus to angle of mandible dividing maxillary sinus into upper (suprastructure) and lower (infrastructure) part.

Ohngren's Classification: Suprastructure has worse prognosis than infrastructure.

- **Incisions/Approaches for maxillectomy:** Weber Ferguson, lateral rhinotomy (Moure's incision), midfacial degloving approach.
- **Esthesioneuroblastoma** ^{PYQ} / **olfactory neuroblastoma** is a highly vascular, tumor of olfactory mucosa ^{PYQ} with rare LN metastasis appears as cherry red polypoidal mass.
- **MC carcinoma of Ext nose** ^{PYQ} → BCC → Also K/a— rodent ulcer.
- **MC carcinoma of Nasal cavity** ^{PYQ} → SCC → Also K/a— nose pickers Carcinoma.

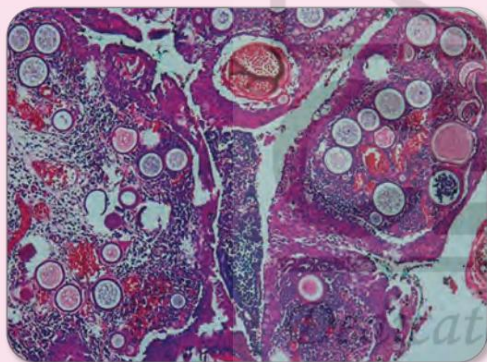
Important Images:



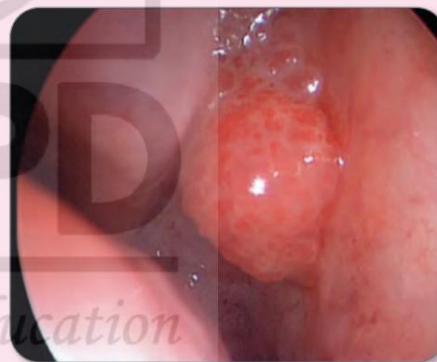
Ohngren's line ^{PYQ}



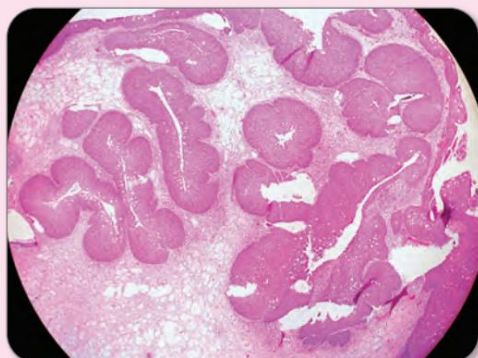
Rhinosporidiosis—Mulberry/strawberry mass ^{PYQ}



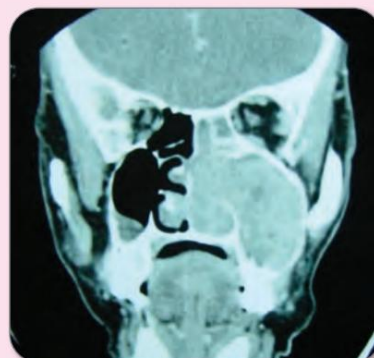
Rhinosporidiosis
Sporangium filled with sporangiospores



Inverted papilloma—Endoscopy ^{PYQ}

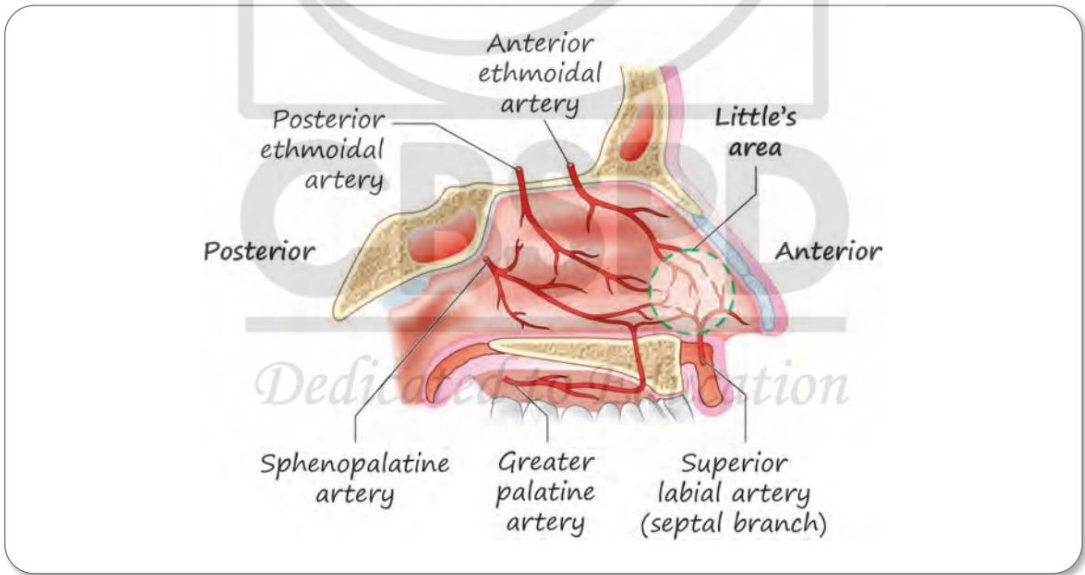
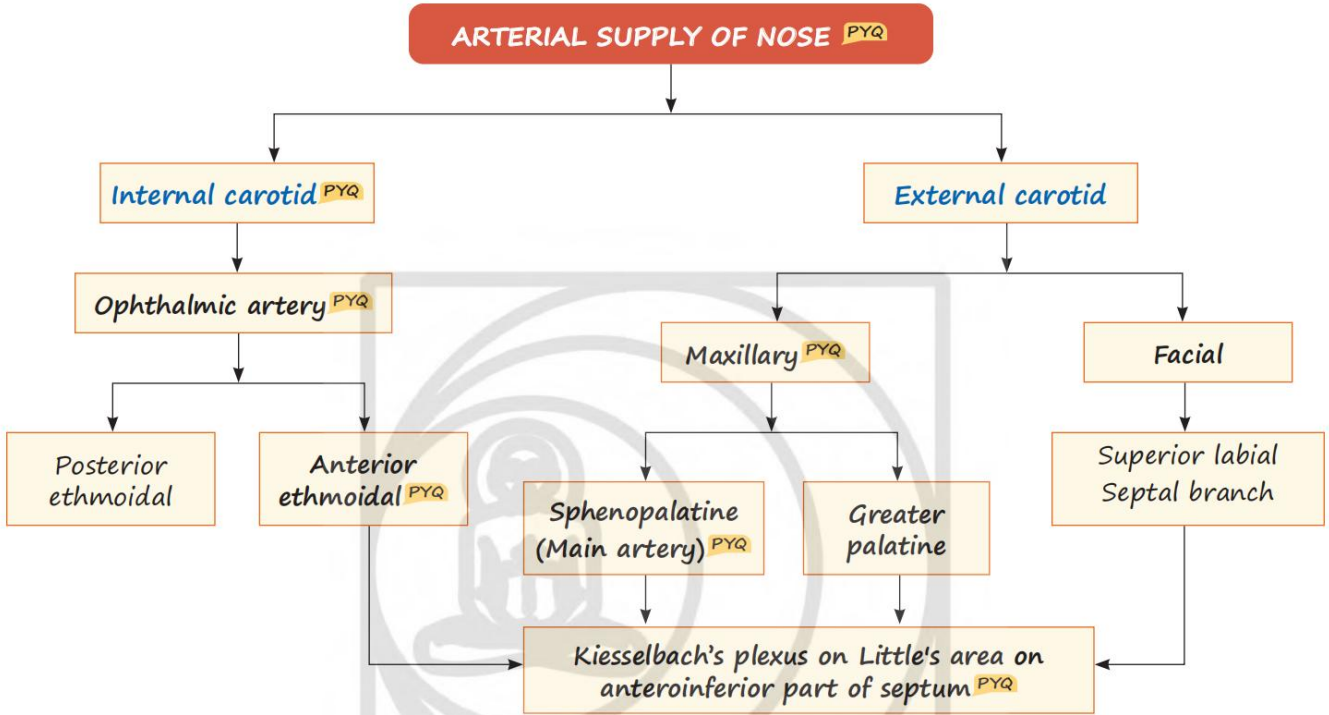


Histopathology of inverted papilloma



Inverted papilloma—CT ^{PYQ}

19. ARTERIAL SUPPLY OF NOSE AND EPISTAXIS



Arterial supply of nose

IMPORTANT PYQs ON EPISTAXIS

- MC site of epistaxis in children and young—Little's area.
 - Location of Little's area—AI part of septum.
 - Arterial Plexus in Little's area is K/a—Kiesselbach's plexus.
 - Artery of epistaxis → Sphenopalatine artery.
 - MC cause of anterior and posterior epistaxis → Sphenopalatine artery.
 - Ligation site of Sphenopalatine artery—at Sphenopalatine foramen 1 cm behind middle turbinate.
 - Artery not contributing to Kiesselbach's plexus—Posterior ethmoidal.
 - Which artery is never ligated to control epistaxis—Internal carotid.
 - Woodruff's plexus—location—behind inferior turbinate.
 - Artery injured during FESS resulting in orbital hematoma—Anterior ethmoidal.
 - Incision for ligation of ethmoidal artery—Lynch Howarth incision.
- MC cause of epistaxis in adults—idiopathic.
- MC cause of epistaxis in Children—Trauma.
- Recurrent epistaxis in young male—Angiofibroma.
- Foreign body in children presentation—MC presentation → unilateral foul smelling nasal discharge.

STEPS FOR MANAGEMENT OF EPISTAXIS PYQ

Check ABC/Vitals



Hippocratic/trotter's method

Hippocratic technique/trotter's method
(with Oxymetazoline if available)



Identify source and Local chemical
(silver nitrate)/bipolar electro cautery



Anterior nasal pack
(All nasal packing admitted and
antibiotic coverage)



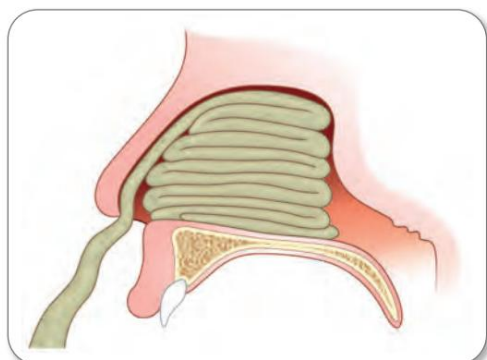
Posterior nasal pack



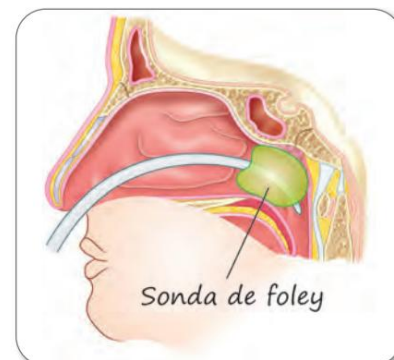
Ligation



Local chemical
(silver nitrate)/bipolar electro
cautery



All nasal packing admitted and antibiotic coverage

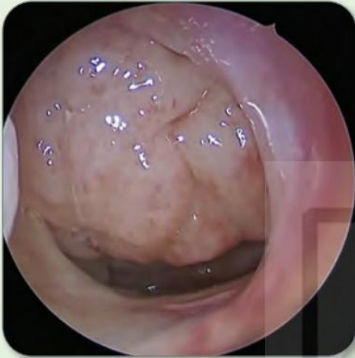


Posterior nasal pack with
foley's catheter

IMAGE-BASED PYQs

Identify.

1.



2.



3.



4.



Ans.

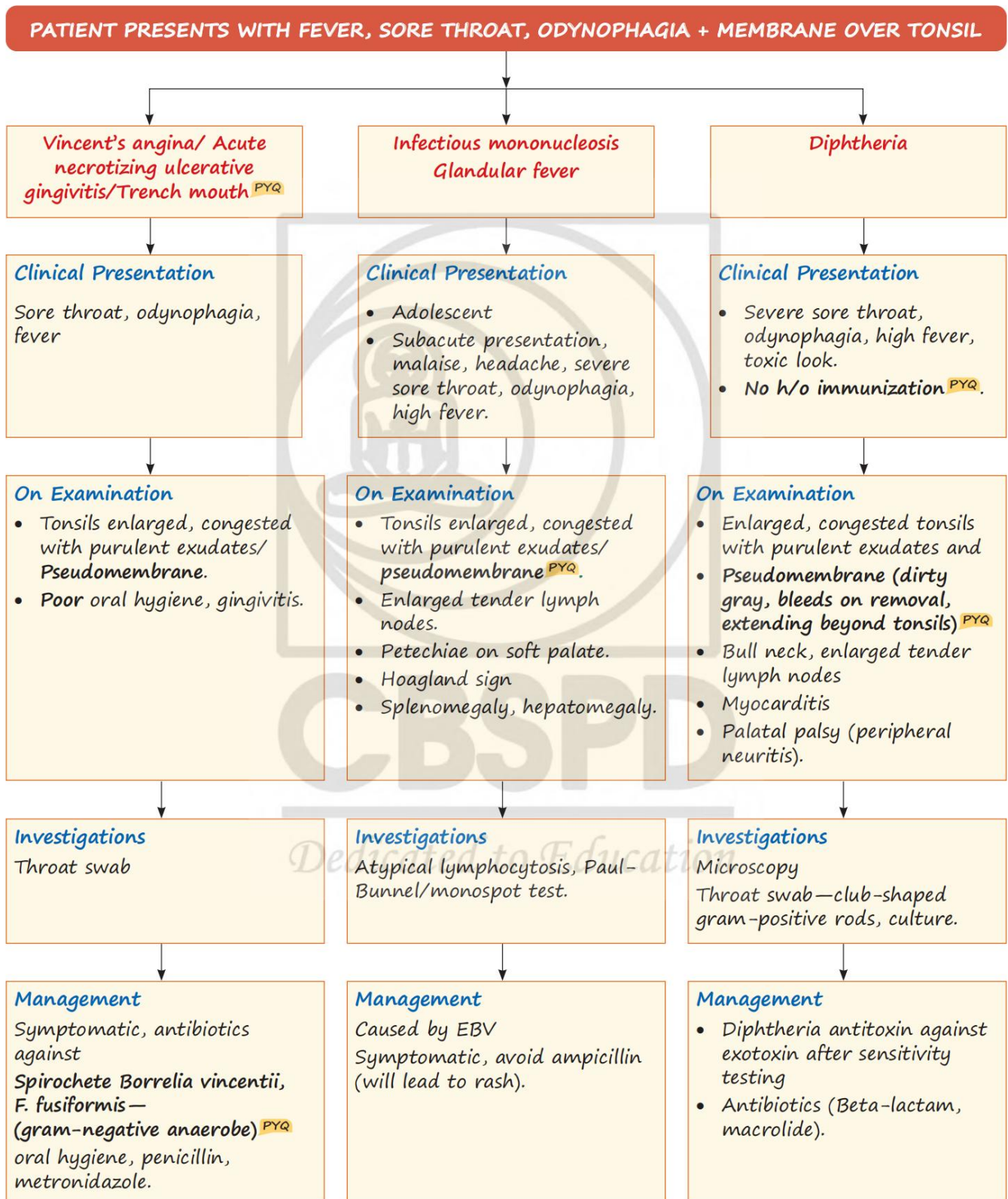
1. Hypertrophied adenoid on endoscopy
2. X-ray nose and nasopharynx lateral view (Dodd/crescent sign -ve), A → Adenoid
3. Adenoidectomy by blind curettage in Rose's position
4. Adenoidectomy by microdebrider under endoscopic visualization

ALSO KNOW

Dedicated to Education

- Passavant's ridge is formed by superior constrictor and palatopharyngeus. **PYQ**
- Incomplete closure of nasopharyngeal isthmus → Velopharyngeal insufficiency (VPI). Voice in VPI—**rhinolalia aperta/hypernasality**.
- **Any obstruction of nose/nasopharynx** → **Rhinolalia clausa**. **PYQ**
- Child with adenoid hypertrophy with Eustachian tube obstruction has future risk of primary acquired cholesteatoma. **PYQ**
- Thornwaldt's bursa **PYQ**/pharyngeal bursa represents the persistence of embryonic communication between the roof of primitive pharynx and notochord. It presents as a blind sac at the junction of the roof and posterior wall of nasopharynx in the midline. It can present as a **nasopharyngeal cyst** **PYQ** or abscess leading to postnasal drip and occipital headache. It is managed by excision or marsupialization **PYQ**.

PATIENT PRESENTS WITH FEVER, SORE THROAT, OODYNOPHAGIA + MEMBRANE OVER TONSIL



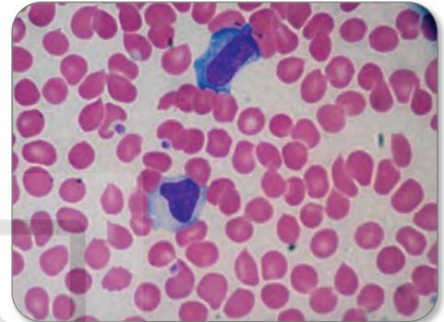
Infectious mononucleosis (Glandular fever)



Enlarged tender lymph nodes of IM



Pseudomembrane



Atypical lymphocytosis

IMAGE-BASED PYQs

Identify.

Diphtheria



Ans. 1. Bull neck; 2. Pseudomembrane

CAUSES OF PSEUDOMEMBRANE ON TONSIL— AL VITAMIN D (MNEMONIC)

- Agranulocytosis
- Leukemia
- Vincent's angina or Trench mouth
- Infectious mononucleosis
- Trauma
- Aphthous ulcers
- Moniliasis (candidiasis)
- Infections of throat
- Neoplasia
- Diphtheria

IMAGE-BASED PYQs

Identify.



Ans.

1. Vincent's angina/Acute necrotizing ulcerative gingivitis/Trench mouth
2. Moniliasis (candidiasis)/Oral thrush (Caused by—Candida, Predisposing factor—Immunosuppression, due to steroid inhaler)

Contraindication for Tonsillectomy ^{PYQ}

- Acute infection
- Bleeding diathesis
- Velopharyngeal insufficiency
- Polio epidemics—virus aggregated in lymphoid tissue—gets access into blood.

Postoperative Care

- Place patient in Recovery/Coma Position → Best protection from airway occlusion or aspiration of fluids into the lungs.
- Watch for bleeding—swallowing, vitals—pulse, BP, respiration monitoring.

TONSILLECTOMY → IMPORTANT POINTS TO REMEMBER**Complications Following Tonsillectomy** ^{PYQ}

- MC C/C following Sx—hemorrhage
 - **Primary**—during Sx
 - **Reactionary**—after Sx to 24 hrs
 - **Secondary** (secondary to infection)—24 hrs to 10 days, most commonly at 5-6 days.

Steps for Management of Hemorrhage ^{PYQ}

Re-exploration under GA → clot removal (for clipping action of superior constrictor) → pressure with vasoconstrictor → cautery → ligate.

IMAGE-BASED PYQs

Identify.

1.



2.



3.

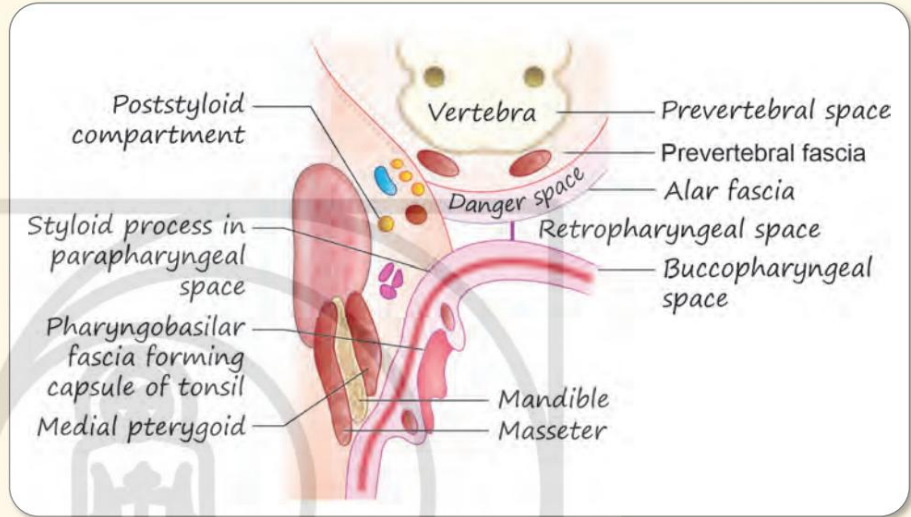


Ans.

1. Mollison's tonsil dissector and anterior pillar retractor
2. Coblation wand
3. Microdebrider

11. RETROPHARYNGEAL SPACE/SPACE OF GILLETTE

Transverse Cut Section at the Level of Tonsil



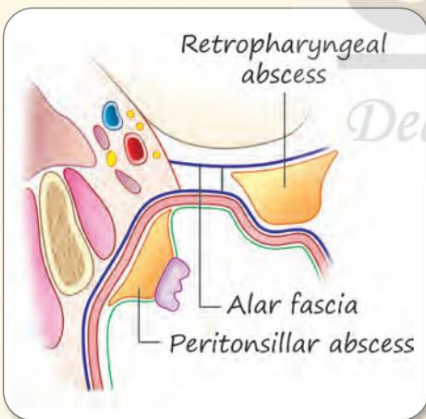
Location

- Between the buccopharyngeal fascia anteriorly and alar fascia posteriorly. **PYQ**
- From base of skull to T₄. **PYQ**
- Has nodes of Rouviere. **PYQ**

ACUTE RETROPHARYNGEAL ABSCESS—
IMPORTANT POINTS TO REMEMBER

Clinical Presentation

Dysphagia, stridor and torticollis. **PYQ**



Unilateral paramedian bulge of posterior pharyngeal wall

Examination Finding

- Unilateral paramedian bulge of PPW.
- X-ray—increased prevertebral shadow, Reversal of cervical lordosis and air-fluid level.



Management

- IV antibiotics
- Intraoral I and D

3. METHODS OF EXAMINING THE LARYNX

METHODS OF EXAMINING THE LARYNX

Endoscopy with or without stroboscope (visualization of mucosal wave in slow motion to differentiate lesions and site of involvement). PYQ

Flexible endoscopy

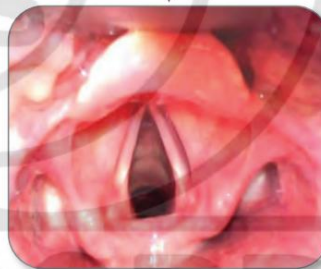


Rigid Endoscopy

Tips of different angles (70, 90)



Indirect laryngoscopy PYQ

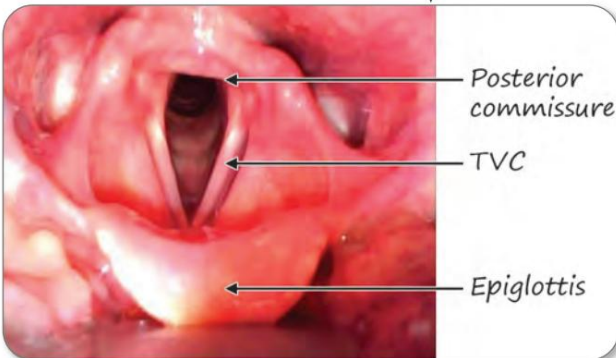


Appearance of larynx

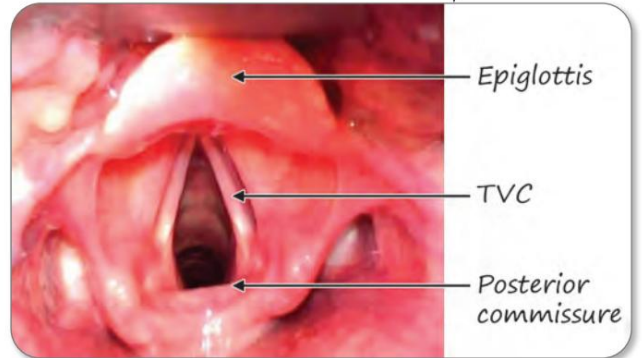
Direct laryngoscopy PYQ



Boyce position PYQ / Chevalier Jackson/Barking dog/sniffing morning air—Flexion at cervical spine and extension at atlanto-occipital joint.



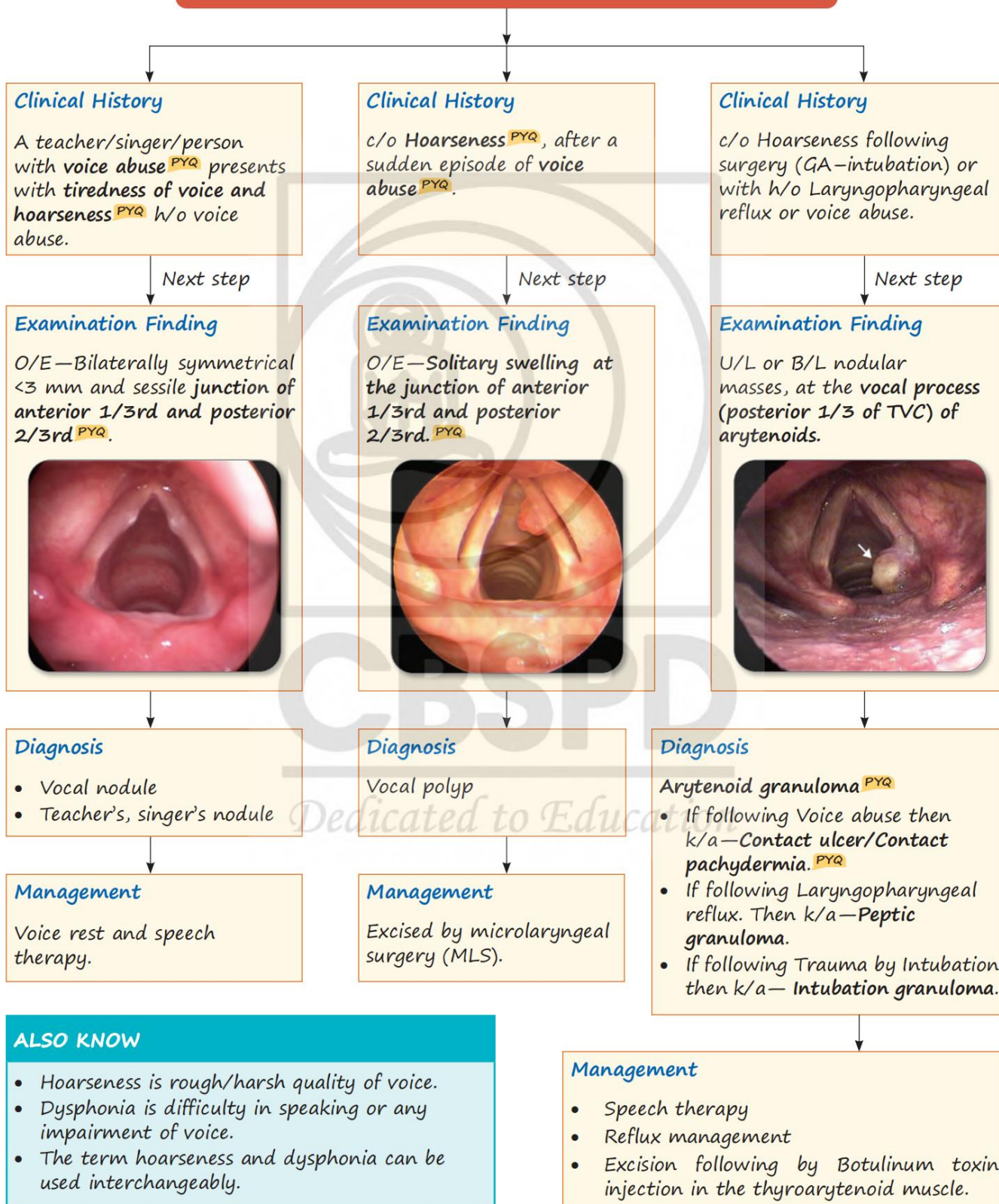
Appearance of larynx



Appearance of larynx

4. CONDITIONS OF LARYNX PRESENTING WITH HOARSENESS

CONDITIONS OF LARYNX PRESENTING WITH HOARSENESS



13. ACUTE INFECTIONS OF LARYNX

ACUTE INFECTIONS OF LARYNX

Epiglottitis

MC Caused by *Streptococcus* PYQ.

Clinical History

- 2–8 yrs
- Acute onset fever, inspiratory stridor
- Odynophagia (drooling of saliva) PYQ
- Normal/muffled cry
- Prefers leaning forward/tripod position
- Stridor Increases in supine and decreases in prone. PYQ

Examination Finding

Pharyngeal examination—**Contraindicated in children** PYQ

- Adults—I/L, FOL
- X-ray soft tissue neck lateral view → Thumb sign. PYQ



Tripod position



Thumb sign

Management PYQ

- Secure airway by—Intubation (first step)
- IV antibiotics (main mgt) PYQ
- Steroids
- Parenteral fluids
- Adrenaline nebulization.

Croup/Laryngo-Tracheo-Bronchitis

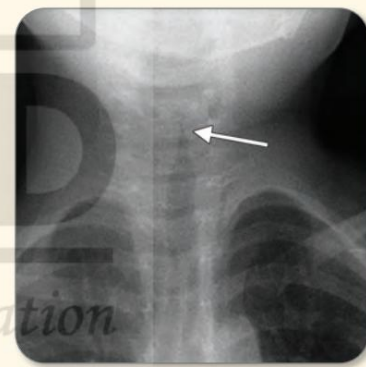
Caused by parainfluenza virus. PYQ

Clinical History

- 6 months–3yrs, boys>girls. PYQ
- Presents with running nose, cold, fever, malaise, Gradual onset, prodromal symptoms present.
- Hoarseness, barking seal like cough, inspiratory or biphasic stridor. PYQ
- Mainly involves—subglottis. PYQ

Examination

X-ray STN AP view—Steeple sign PYQ / Pencil tip sign.



Management PYQ

- Steroids (main management)
- Adrenaline nebulization, humidification, hydration.



ONE Touch ENT



Salient Features

- **Theory**—A concise form of text covered in just 190 pages and most important points to remember are given from the examination point of view. The text is designed in accordance with the recent CBME and NEXT exam curriculum.
- **High Yield Tables**—Frequently asked Topics and clinical correlations are tabulated for ease of learning and more visual impact for long-term memory.
- **Clinical Images and Illustrations**—Clinical Images and Illustrations are given in the form of Images, Figures, Flowcharts, Tables, etc. along with their descriptions.
- **Previous Year Qs**—Important Topics/Qs have been highlighted in-between the text giving a quick glance over the important topics from exam point of view—questions have been asked from the respective topic in previous year examination.
- **Recent Questions**—Last 3 years' exam question papers up to July 2023 are provided to develop an idea about the trend of questions and also to know about the recently asked topics.

About the Author

Manisha Sinha Budhiraja, MBBS, MS (ENT), DNB (ENT) is an eminent ENT surgeon and alumna of the prestigious Lady Hardinge Medical College (LHMC), New Delhi. She holds an MS in ENT from the esteemed Safdarjung Hospital, Delhi University. She is also a Diplomate of National Board (DNB, ENT). She has worked in the departments of ENT at Safdarjung Hospital and Acharya Shri Bhikshu Govt. Hospital, Delhi.



The author has been teaching ENT for the past 17 years now all across India and is one of the best faculty members. She has an immense command over the subject. A prominent faculty member recognized for her ability to make the subject easy and interesting to learn, has also conducted numerous teaching programmes on the subject matter devoting over 15,000 hours and still counting. An expert ENT clinical and surgeon, she has been associated with reputed private hospitals, apart from practicing at her own ENT clinic. She is also benefitting the students through her Facebook group www.facebook.com/groups/manishasachin/

About the Editor

Sachin Budhiraja, MBBS, MD is an astute of medicine. He did his MBBS from the renowned University College of Medical Sciences (UCMS, Delhi) and MD (Medicine) from the esteemed Safdarjung Hospital, Delhi University. His passion of teaching in spite of his busy schedule has made many difficult topics of medicine easy to grasp. He has been teaching medicine for the past 15 years now across India.



CBS Publishers & Distributors Pvt. Ltd.

4819/XI, Prahlad Street, 24 Ansari Road, Daryaganj, New Delhi 110 002, India

E-mail: feedback@cbspd.com, Website: www.cbspd.com

New Delhi | Bengaluru | Chennai | Kochi | Kolkata | Lucknow | Mumbai

Hyderabad | Jharkhand | Nagpur | Patna | Pune | Uttarakhand

ISBN: 978-93-90619-97-9



9 789390 619979