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## Bilateral hearing asymmetry and lateral differences in susceptibility to noise damage

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The medical-legal evaluation of asymmetric paths in the field of hearing loss noise is extremely complex and still not unique. The critical issues regarding the definition of asymmetry in the literature are numerous and sometimes seemingly irreconcilable. Scholastically the noise deafness is characterized by being hearing loss perceptive, bilateral and symmetric. The American College of Occupational and Environmental Medicine in 2002 indicates the first two criteria for defining N.I.H.L (Noise Induce Hearing Loss): It is always sensorineural, affecting the hair cells of the inner ear and; it is almost always bilateral. Usually audiometric patterns are similar. Asymmetry supports since most noise exposures are symmetric, the hearing typical loss is bilateral. When evaluating cases of asymmetric loss, referral to rule out in the back-first cochlear lesion is warranted before attributing the loss to noise. The work of Prasad, Sabini and Fernandes state that asymmetrical sensorineural hearing loss (ASNHL) is defined as binaural difference in bone conduction thresholds of >10 dB at two consecutive frequencies or >15 dB at one frequency (0.25-8.0 kHz). This also appears our own convictions. For noble and gatehouse, asymmetry was defined as an interaural difference of blackberries than 10 dB in hearing levels averaged over 0.5, 1, 2 and 4 kHz. Interaural level difference, interaural time difference, direction dependent filtering, minimum audible angle explains how the sound localization can come differently to the two ears. The author aims to classify 10 causes of asymmetry in deafness due to professional noise.

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## Postmenopausal cutaneous endometriosis: A delayed atypical presentation

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Cutaneous endometriosis is rare and represents less than 5.5% of known endometriosis cases. Endometrioma typically occurs in women of reproductive age. However, we describe a postmenopausal case of cutaneous endometriosis with an atypical presentation. A 66-year-old woman presented to the surgical assessment unit with a short history of a new palpable umbilical lesion. Nine months prior she had been diagnosed with invasive lobular breast carcinoma. Her treatment consisted of a mastectomy with axillary nodal clearance and radiotherapy. Her medical history included a hysterectomy and bilateral salpingo-oophorectomy for endometriosis (2000) and laparoscopic appendectomy (1986). She had been taking anastrozole following her breast cancer surgery. A computed tomography staging scan excluded metastatic spread. An ultrasound described a soft tissue umbilical mass, biopsy of the mass revealed endometrial type glands with surrounding endometrial type stroma which appeared non-functional. Subsequently, an approach of 'watchful waiting' was adopted instead of surgical excision. Our patient did not present with typical symptoms of endometriosis, such as cyclical pain or bleeding. We hypothesize that the endometrial cells had implanted following her previous surgeries. However, this secondary form of cutaneous endometriosis presented markedly late and seemed to occur in the context of anastrozole (aromatase inhibitor). Clinical presentation of cutaneous umbilical endometriosis can mimic malignancies; especially in the context of recently diagnosed cancer. Histopathological examination is the gold standard and the diagnosis will exclude malignancy. Further clinical studies are needed to investigate the efficacy of aromatase inhibitors in the postmenopausal endometriosis before it can be considered a reliable treatment option.

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