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Difficult Situations in Cholesteatoma Surgery (N713)

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Difficult Situations in Cholesteatoma Surgery

Presenting Author: **Mohan Kameswaran**

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Learning Objectives: In the Indian subcontinent, the otologist faces several challenges in cholesteatoma surgery due to the high prevalence of the disease and late presentation with advanced disease. Cholesteatoma extending into the oval / round windows, semicircular canal, or the internal auditory meatus are encountered. Revision surgery can be particularly challenging. This presentation will focus on these difficult situations in cholesteatoma surgery.

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Middle ear Implants – indications (R714)

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BCI or AMEI: how to select the right patient with chronic middle ear disease

Presenting Author: **Maurizio Barbara**Maurizio Barbara¹, Simonetta Monini², Chiara Filippi², Francesca Atturo³¹*Sapienza University Rome*, ²*Sapienza University, NESMOS Department, Rome, Italy*,³*Sapienza University, NESMO Department, Rome, Italy*

Learning Objectives: To give some hint of the principles that should drive for an appropriate selection of the correct auditory implantable device in case of chronic middle ear disease.

Background: Bone Conductive Implants (BCI) are widely used since several decades for the auditory rehabilitation of conductive and mixed hearing loss as well as for Single-sided Deafness (SSD). In mixed hearing loss, the role of Active Middle Ear Implants (AMEI) has recently been emphasised, with application and direct driving of the remnants of the ossicular chain or on the round window membrane. The present study aims to identify the best

candidature on the ground of pre-operative personalised headband test.

Material and Methods: At the Implanting Center of Rome La Sapienza, Sant'Andrea Hospital, a consecutive series of subjects were evaluated for an auditory rehabilitation involving the use of electronic, surgically-implanted devices. A thorough audiometric evaluation was performed under the unaided condition and when wearing a simulation device, such as with the headband, personalised according to the individual subject's performances. The clinical conditions related to the ear pathology or to an eventual surgical sequel were also taken into account.

Results: A BCI was indicated in all cases with conductive hearing loss and in the mixed cases when the BC threshold was not measured beyond 40 dB at all the tested frequencies. When the BC threshold was beyond this threshold limit but not beyond 65 dB especially at the high frequencies, an AMEI was advised. Considering that these advanced mixed cases were often present as a sequel of open tympanoplasty for cholesteatoma, a round window coupling of the AMEI was advised.

Discussion: A thorough, individualised pre-operative test represents the best approach for the choice of the rehabilitative device, especially in absence of precise guidelines. From our experience, a round window application could always be indicated in stable, open tympanoplasty sequel and a concomitant advanced form of mixed hearing loss.

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Cholesteatoma in Children (N715)

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Management of Congenital Cholesteatoma

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Learning Objectives: In this presentation different forms of congenital cholesteatomas will be presented together with management strategies.

Between 2003–2016 author performed 817 tympanoplasties. 318 of these had cholesteatoma. 38 of these are classified as congenital cholesteatoma. 29 are primary cases and remaining 9 are revision cases. While three of the revision cases belong to the author, in remaining cases original operation had been performed in another center.

Youngest patient operated was 7 months old diagnosed with hearing screening.

Congenital cholesteatomas confined to the middle ear are usually attached to the neck of the malleus necessitating the removal of the neck and head of the malleus for complete removal. This can be managed without damaging the tympanic membrane. Ossicular chain is reconstructed with bone cement.

Larger cholesteatomas necessitate mastoidectomy with or without open cavity.

There is a group of congenital cholesteatoma extending into petrous bone. Resulting cavity can be managed by blind sac closure of the ear canal with subtotal petrosectomy.