

primarily due to operating one-handed, but also adjusting to the different view achieved with the endoscope.

Methods: This study shows a preliminary retrospective overview of a consecutive series of all endoscopic ear surgery cases performed by one ENT-surgeon since starting his EES practice two years ago.

Results: Hundred and five consecutive patients were included in the study group, including 46 cholesteatoma cases, 52 type 1 tympanoplasties and 7 PORP ossiculoplasties. No major adverse events or incidences were noted. In 3 cases the endoscopic approach had to be converted to a microscopic post auricular approach for complete removal of cholesteatoma. Overall, 9 out of the 105 surgeries (8.6%) resulted in a post-operative residual perforation. In one case recurrence of cholesteatoma was noted 21 months post operatively. Overall average follow-up time was 6.4 months (range 1–20 months).

Conclusions: Results demonstrate that a surgeon can pick up the necessary skills relatively quickly and achieve acceptable success rates while delivering the reduced morbidity associated with EES.

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Retraction Pocket (N863)

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The role of endoscopy in retraction pockets

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Background: It is well known that Eustachian Tube (ET) plays a crucial role in maintaining middle ear aeration and atmospheric pressure. Usually inflammatory middle ear chronic disease is related to ET dysfunction due to poor tympanic ventilation. Although middle ear aeration is certainly related to ET function, other anatomic factors play an important role in ventilation of these spaces. Actually epitympanum aeration is strictly dependent to the ventilation pathways; if the tensor fold and the lateral incudo-malleal fold are complete the only ventilation pathway to the epitympanum is through the tympanic isthmus. In such cases when an isthmus blockage occurs the ventilation of epitympanum may be impaired and the only gas exchange would come from the mucosa of mastoid cells. This scenario describes a selective epitympanic disventilative syndrome, possibly not related to ET impairment.

With introduction of the endoscope in middle ear surgery, anatomy of middle ear spaces has become wider and clearer due to a better magnification and to the possibility to look “behind the corner” and to better understand the ventilation pathways, particularly in patients with retraction pockets.

Materials and methods: From December 2008 to December 2015, 470 tympanoplasty were performed with exclusive endoscopic approach; All patients candidate to ear surgery underwent to high resolution CT-scan, audiometric

and impedenzometric evaluations. Inclusion criteria in our study were patients affected by not-self cleansing attic retraction pocket. Subjects affected by a disease of the epitympanic compartments (not self cleansing retraction pockets of the attic; epitympanic cholesteatoma) and with type A tympanogram were included in present study.

Exclusion criteria: subjects affected by a disease involving the protympanic, the mesotympanic and the retrotympanic region, or patients who previously underwent middle ear surgery.

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Retraction Pocket (N863)

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Paediatric retraction pocket: prevention and treatment

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Learning Objectives: To discuss the classification, prevention and treatment of pediatric retraction pockets.

Tympanic membrane retraction pocket (RP) is defined as an inward displacement of the TM from its normal position. It is characterized by partial collapse of the meso or epitympanic spaces, which correspond clinically to a retraction of a portion of the TM in its pars tensa (PT) or pars flaccida (PF). Even if several classifications have been proposed, there is not a consensus in the treatment of this condition. The available classification systems will be reviewed as well as the medical and surgical treatment proposed.

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Retraction Pocket (N863)

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Retraction Pockets: Overview and Randomized Study

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Background: The attitude of treatment of retraction pockets (RP) depends on several factors that include age of the patient, stage of the disease and patient’s compliance. Silent forms usually do not need any surgery, although the presence of predisposing factors (craniofacial malformations, for example) and/or the young age could indicate a preventive surgical procedure. For the advanced stages, where periodical accumulation of debris occurs, surgery would seem to be mandatory.