

Nasopharynx. Second being Canal skin and Tympanic membrane epithelium which exfoliates epithelium and is exteriorised. After surgery if this natural cavities loose their anatomy, operated cavity will no longer be dry or healthy in long term.

After complete canal down mastoidectomy two types of mastoid cavities can be found - First -completely sclerosed – means there remains no visible mastoid cells at the floor-here a large and thin fascia is lined to cover all the cavity and it epithelises and Second - cellular cavity (it is always not possible to exenterate all the air cells or at least impractical) – in which after complete Mastoidectomy, there still remain some cells at the floor. If this cavity is lined by fascia or cavity filling is done, the remaining air cells will keep on secreting mucus and granulate and the cavity will no longer be dry. A new method of solving this problem is - Conchal cartilage which is harvested at the time of meatoplasty is thinned out and laid down in cavity with convexity upwards so that it creates a small cavity communicating to aditus and then to middle ear and large fascia is lined over it.

Out of 102 canal down mastoidectomies we found primary healed cavity in 64 which never had cavity problem, 33 cavities were showing minor granulations and were cured with Trichloroacetic acid,steroid packing or drops.3 came to be tubercular and 3 never became dry in 15 months follow up.

The benefit of this procedure is that the cartilage needed is already harvested by meatoplasty, time saving as no cartilage fixation is needed to create a separate wall, time saving, reduces the size of cavity, primary healing occurs as full cavity is lined by fascia and no raw bone is exposed.

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### Vestibular schwannoma growth after stereotactic radiosurgery

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*Learning Objectives:* 1) To clarify the natural history of vestibular schwannoma and outline treatment options 2) To present two cases of abnormal vestibular schwannoma growth following STRS 3) To discuss potential reasons for tumour growth after STRS 4) To confirm the need for life-long radiological and clinical surveillance following STRS.

*Introduction:* Vestibular schwannomas, are benign tumours of Schwann cell origin that occur on the eighth cranial nerve. Commonly presenting symptoms include hearing loss, tinnitus and balance disturbance. Tumour progression can lead to brainstem compression, cranial neuropathies and hydrocephalus. Smaller, slow-growing tumours can be safely observed, but larger tumours necessitate treatment in the form of either surgery or STRS. The literature states that tumours up to 3 cm in diameter can be successfully controlled in the majority of patients with STRS, and a recent Cochrane review concludes that the treatment method for large vestibular schwannomas should be chosen on an

individual basis, taking into consideration the patient's preferences, clinician experience and the availability of radiotherapeutic equipment.

*Methods:* We present two cases of vestibular schwannoma which were treated with STRS, and decreased in size during the two years following treatment, following which they began to exhibit further growth.

*Discussion:* Pseudoprogression of vestibular schwannomas for up to two years following STRS is a well-documented phenomenon, following which the oedematous tumour regresses in response to the STRS.

Potential reasons for tumour growth over two years after STRS are malignant transformation of the tumour, and late failure of STRS. Although rare, there is a documented risk of malignant change following exposure to radiation. Late failure of STRS is possible if, despite an early response to STRS, living cells within the tumour develop an adequate blood supply for growth.

*Conclusions:* Vestibular schwannoma patients warrant life-long radiological and clinical surveillance following STRS, as there is a small chance of initial regression followed by further growth. These cases therefore require surgery, for tumour removal and histological diagnosis.

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### Management of the intact, mobile stapes: a 12 year experience

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*Learning Objectives:* 1) To clarify the goals of tympanomastoid surgery 2) To present a single surgeon's 12 year cohort of patients 3) To determine hearing outcomes in patients with an isolated, intact, mobile stapes and aerated tympanum following tympanomastoid surgery 4) To compare the outcomes of Type III cartilage tympanoplasty with published results of various ossicular prostheses in similar patient groups. 5) To recommend management guidelines for hearing preservation in patients with an isolated, intact, mobile stapes

*Introduction:* The goals of tympanomastoid surgery are the elimination of disease and the preservation of good hearing function. There is much literature on this topic, and it is understood that a mobile stapes and aerated tympanum are essential for a successful type III tympanoplasty, and that the interposition of a cartilage disc between stapes and tympanic membrane graft can improve audiometric results. However, there is heterogeneity amongst reported case series, and conflicting reports regarding the use of ossiculoplasty materials. The aims of this paper were to analyse hearing outcomes from a 12 year cohort of patients with an isolated, intact, mobile stapes following tympanomastoid surgery; to compare primary cartilage reconstruction with