

*Case presentations:* Case 1 was a 31-year-old female with right conductive hearing loss and no episodes of facial paralysis. CT/MRIs revealed a facial neuroma located in the genu through the tympanic segment. During the TMA the tumor was found to involve the labyrinthine segment, and thereby supralabyrinthine MF plate was drilled out to search the normal facial nerve proximally. This addition of partial craniectomy facilitated successful removal and cable graft.

Case 2 was a 42-year-old male with right conductive hearing loss. CT scans showed an epitympanic cholesteatoma extending to supralabyrinthine cells. Since the pathology was intraoperatively found to extend over the labyrinth and to invade the superior semicircular canal, tentative removal of the MF plate was decided during the TMA to achieve the complete removal without damaging the labyrinth.

*Discussion:* MF craniotomy usually needs an assistance of neurosurgeons, and therefore this approach seems difficult to add to TMA in a single operation depending on the intraoperative findings. Supralabyrinthine lesions still have a chance to be removed via TMA alone. If the pathology is found to extend more medially than expected during the TMA, an additional removal of the MF plate enables us to treat the lesions more easily under the more familiar surgical view.

*Conclusion:* Transmastoid MF craniectomy provides ear surgeons with better surgical access for laterally localized lesions in the petrous apex, and is indicated into supralabyrinthine cholesteatomas and facial neuromas.

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### The Natural History of Advanced Pars Tensa Retraction Pockets

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*Learning Objectives:*

*Intro:* The limited evidence available to guide management has rendered very controversial the management of pars tensa retraction pockets.

Since 2003, we have adopted a policy of minimal intervention for pars tensa retraction pockets and this has allowed us to monitor the natural behaviour of this disorder.

*Method:* Successive patients with pars tensa retraction pockets that a) contacted the promontory yet b) were not accumulating keratin (“advanced retraction pockets”) have been monitored at least once a year and followed either until surgery was required, the patient was lost to follow-up or some other pathology intervened. Follow-up was censored at five years.

*Results:* 95 cases were enlisted and followed up.

25% ears advanced to need surgery.

40% ears remained advanced without further progression.

38% ears returned to normal.

4% ears developed pars tensa perforation.

3% ears developed attic cholesteatoma.

*Conclusions:* Only a minority of advanced pars tensa retraction pockets progress to require surgery.

More advanced pars tensa retraction pockets return spontaneously to normal than progress to require surgery.

Some ears that present with a retracted pars tensa progress to develop attic retraction and then attic cholesteatoma, without developing cholesteatoma via the pars tensa.

*Learning Points:* It is not correct to consider an advanced pars tensa retraction pocket as necessarily pre-cholesteatoma.

Because most advanced pars tensa retraction pockets do not progress to become cholesteatoma, surgery on advanced pars tensa retraction pockets cannot be justified on the grounds that it is prophylaxis against the development of cholesteatoma.

Attic and pars tensa retraction disease sometimes have a common aetiology.

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### Posterior ear canal reconstruction as a simple alternative to mastoid obliteration

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*Learning Objectives:*

*Intro:* The treatment of discharging mastoid cavities is hampered by long-term deterioration of the surgical reconstruction.

We hypothesised that it would be optimal to use a graft that would become incorporated into, and indistinguishable from the skull bone.

We developed a simplified technique of posterior canal wall reconstruction using a free cortical bone graft in patients who have discharging mastoid cavities.

*Method:* Technique: Reconstruction of the posterior canal wall with a free cortical bone graft harvested from the cortex of the mastoid process.

*Patients:* 40 patients with discharging mastoid cavities.

The following were assessed at one year following surgery:

1. Integrity of the barrier formed by the cortical bone graft.
2. Integrity of the keratinising epithelium of the ear canal.
3. Patient report of ear discharge.

*Results:* Adequate bone grafts were obtainable in all cases.

An intact barrier between the mastoid cavity and a new, physiological ear canal were maintained at one year in all cases, bar one, when a recurrent cholesteatoma developed through a defect between the graft and facial ridge, whereafter the technique was modified.