pt satisfaction and QOL after MCO using cartilage. It was also directed to find out post-op dry ear, wax problems, dizziness & recurrence.

Methods: In our cohort study, 29pts with CDE underwent revision mastoidectomy with MCO/PCR during Jul'11-Jun'15. They were followed at 6wks, 4, 6 & 12mths post-op.Symptoms were noted in pt files during followup visits & collated on excel chart. QOL was assessed using Glasgow Benefit Inventory Score. Response was obtained by posting proformas to pts.Ethical approval was obtained from trust R&D.

Results: The procedure was successful in improving QOL in majority. 26/29 pts reported dry ears. 2 pts continued to have discharge &1 underwent repeat surgery. Frequency of clinic visits has reduced significantly. >90%pts reported significant improvement in QOL & less visits to GP surgery.

Conclusion: The outcome and QOL improvement after MRM/PCR using cartilage is satisfactory. Frequently encountered problems of chronically discharging ear, wax and dizziness are reduced.

Keywords: **C**hronic otitis media, mastoid cavity obliteration, cartilage graft, QOL, Glasgow Benefit Inventory Score.

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Delayed presentation of a giant congenital cholesteatoma with cerebrospinal fluid fistula

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Learning Objectives: Cholesteatoma can exist for many years with little or no symptoms before presentation with life-threatening complications. Patients with persisting ear discharge should undergo CT scanning of the temporal bones.

Introduction: Cholesteatoma is usually acquired. Congenital cholesteatoma is rare and occurs at three important sites: the middle ear, the Petrous apex, and CPA. For the diagnosis to be made the following three conditions should normally apply: there should be a mass medial to the tympanic membrane; the tympanic membrane should be normal and intact and there should be no previous history of ear discharge, perforation or ear surgery. Presentation of congenital middle ear cholesteatoma is normally as a conductive hearing loss in childhood. Petrous apex and cerobellopotine cholesteatomas may present with CPA symptoms or be picked up as in incidental radiological finding in early adult life.

Method: A 54 year old man presented with a short history of hearing loss and ear discharge. He was treated for otitis externa and wax. Microsuction was performed several times before a CT scan of the temporal bones was requested which showed a massive erosive lesion consistent with a giant cholesteatoma (images). As he was leaving the consultation he asked for further micro suction. This provoked a profuse CSF leak. Urgent tertiary referral was made and the patient underwent craniotomy and petrosectomy(operative photographs).

Results: The patient recovered well with no cranial nerve deficits or other complications and is managing well a CROS hearing aid. Four years on he remains well with no sign of recurrence on two diffusion weighted MRI scans(images). He remains under lifelong surveillance.

Conclusion: Congenital cholesteatoma can remain silent for many years presenting late in life as a giant cholesteatoma with bony erosion and extension into the cranial cavity. CT and diffusion weighted MRI imaging can help in diagnosis and pre-operative planning.

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External ear canal cholesteatoma: Two in a day!

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Learning Objectives: External Ear Canal Cholesteatoma, even when very extensive, can be successfully treated with excellent hearing outcomes.

Introduction: The aetiology of external ear canal cholesteatoma (EECC) may be traumatic, iatrogenic or spontaneous. It is a rare entity with an estimated incidence of around 1 in 1000 patients requiring otologic surgery. Remarkably, we present two cases operated on same the day by the senior author!

Methods: 2 cases are presented including pre-operative imaging. An 80 year old female who presented with a 3 month history of left-side hearing loss. Microsuction for "hard wax" was performed several times before CT scan was requested. A 61 year old female with a short history of left-sided hearing loss and pain. Hard "wax" was removed by microsuction several times. The tympanic membrane was seen to be normal and she was discharged before representing with the same symptoms. Eventually a CT scan was requested. Both patients underwent modified radical mastoidectomy. In the first case the cholesteatoma sac was seen to be originating from the anteroinferior wall of the ear canal and extending into the mastoid. The tympanic membrane was intact and middle ear uninvolved. The second patient was found to have cholesteatoma arising from the posteroinferior wall of the ear canal with extension into the mastoid and petrous bones.Middle fossa dura was widely exposed by the disease. The lateral SCC was dehiscent. The tympanic membrane was normal and the middle ear uninvolved.