Presenting Author: **Shueh Lim**

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Learning Objectives: Middle ear adenomas are rare benign tumours. Surgery remains the mainstay of treatment. Longterm follow up should be carried out. Middle ear adenoma should be included in the differential diagnosis of middle ear mass in patients with persisting, non-specific symptoms.

Introduction: Middle ear adenoma is a low-grade neoplasm with the potential for recurrence and metastases. Clinical and radiological findings can be misleading and often fail to provide the right diagnosis. Our objective is to present our experience over a 10 year period.

Methods: A retrospective review of all middle ear pathology at our tertiary referral centre with a catchment area of over three million over the last 10 years was carried out.

Results: In total, only three patients were identified (prevalence 1:1,000,000), two male one female. Common symptoms of presentation included conductive hearing loss, aural pressure and autophony. Detailed imaging (computed tomography, magnetic resonance imaging complimented by angiography) was employed to better characterize the lesion and help with surgical planning. All patients underwent middle ear/ lateral skull base surgery. One patient had revision surgery for recurrence. Because of the neuroendocrine nature of ME adenomas, all patients remain under postoperative surveillance.

Conclusion: Our experience is similar to published literature. Adenomas of middle ear are indistinguishable benign tumours; surgical excision should be carried out to ensure complete excision.

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Intracranial Complications from Chronic Otitis Media

Presenting Author: **Richard Locke**

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Learning Objectives: Intracranial complications from middle ear disease Patterns of presentation Management of intracranial complications

Middle ear disease remains relatively common in the UK population with a previous study revealing the prevalence of inactive chronic otitis media to be 2.6% and active chronic otitis media to be 1.5% in the adult population. The incidence of intracranial complications from middle ear disease has fallen, however these life threatening complications are often diagnosed late and need to be treated aggressively.

We performed a retrospective analysis of patients referred to a tertiary neurosurgical centre with intracranial complications from both mucosal and squamous middle ear disease. The case notes and imaging were reviewed for comparison. Patient age, symptom duration, type of middle disease, management, complications and outcomes were determined. The results were then compared with a similar analysis performed at the same institution 20 years previously.

The majority of patients had active squamous otitis media. Previous surgical treatment of cholesteatoma did not prevent development of intracranial complications when there was recurrent disease. Meningitis was the predominant intracranial complication with venous sinus thrombosis and abscess rates lower. One patient developed a false aneurysm of the internal carotid artery from active mucosal otitis media.

There has been little change in the range of complications encountered over the past 20 years. For conditions such as false aneurysms, advances in interventional radiology have led to improved outcomes.

We present these cases to highlight the issues regarding diagnosis and management of patients with intracranial complications from chronic middle ear disease. High index of suspicion and aggressive surgical treatment remain essential as delay in diagnosis or treatment can be catastrophic.

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Cholesteatoma: How it grows and where it goes, and how we should therefore approach its surgery: An analysis of data collected prospectively on 516 cases.

Presenting Author: **James Loock**

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Learning Objectives:

Introduction: While all otologists operate on cholesteatoma, little analysis exists of the patterns of disease spread which logically should dictate surgical approaches. Nor has comparison been made between different parts of the world.

Method: A detailed data-base was prospectively collected on every cholesteatoma surgery in Tygerberg Hospital between 2003 and 2016 (n = 516). This included *inter alia* the cholesteatoma's origin from the tympanic membrane, and its presence/not in all parts of the mesotympanum, epitympanum and mastoid. This data is analysed for the various sites and subsites and the site of origin of the cholesteatoma.

Results: Surprisingly, the tympanic membrane origin was: pars flaccida 27%, pars tensa posterior-superior marginal 29%; pars tensa central 30 %; and indeterminate 13% (some had multiple origins).