MALIGNANCIES OF THE EXTERNAL AUDITORY CANAL AND TEMPORAL BONE: A REVIEW

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Background: Malignancies of the external auditory canal and temporal bone are rare. We have reviewed a series of 59 cases treated in our centre over the period 1974 to 1995.

Methods: Retrospective review of patient histopathology, type of surgery, resection margin status and survival. A TNM staging classification was applied and stage-specific Kaplan-Meier survival analysed.

Results: The series contained 37 SCCs and 15 BCCs plus some other less common lesions. 73% of cases were recurrences, including 10 failed ear canal cancers and 33 recurrent cutaneous periauricular lesions. Twenty sleeve resections, 30 lateral temporal bone resections and 9 subtotal temporal bone resections were carried out.

Overall 5 year survival for the group is 54%. Survival by stage is stage 1:90%, stage 2: 45%, stage 3: 40%, stage 4:19%. Survival is significantly higher when clear surgical margins are achieved (80% vs 35%). Survival is noticeably better for BCC compared to SCC.

Conclusions: Carcinoma of the ear canal and temporal bone is rare and in this Australian series often results from recurrence of cutaneous periauricular lesions and medial infiltration. Surgical extirpation provides the best survival when clear margins are achieved.

A SIMPLE TECHNIQUE FOR CLOSING ANTERIOR MARGINAL TYMPANIC MEMBRANE PERFORATIONS

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Anteriorly placed tympanic membrane perforations are notoriously difficult to repair surgically. Complex operations which involve drilling the anterior canal and then placing tags of temporalis fascia beneath the annulus are awkward to perform especially if there is any bleeding. Failure rates are high and complications such as anterior canal blunting can mar the outcome.

A simple technique is described which only takes 20 minutes to perform. A small incision is made immediately behind the pinna and the canal wall transected. It is usually possible to see the whole of the perforation without removing any anterior canal wall overhang. The edges of the perforation are freshened and the annulus anterior to the perforation is displaced. A template is used to measure the exact size and shape of the perforation. A thin piece of cartilage is then taken from the pinna and shaped according to the template. The cartilage is then inserted into the groove of the annulus and placed under the tympanic membrane.

Over the past 5 years, 27 perforations have been closed using this technique. The success rate is 85%.

RIGID ENDOSCOPY IN NEURO-OTOLOGY

M. SCHULZT

Rigid endoscopes are used extensively in otolaryngology - head and neck surgery, particularly in the field of rhinology. It is only relatively recently, however that their use in surgical neuro-otology has begun to gain acceptance. The special optical qualities of Hopkins rod telescopes lend themselves to use in surgical procedures within the posterior cranial fossa where their depth of field and ability to visualise structures obscured from direct view can prove extremely valuable.

Coupled with current generation video cameras, rigid endoscopes can therefore provide a very useful adjunct to the operating microscope in surgery of the cerebellopontine angle, internal auditory meatus and petrous temporal bone.

This presentation describes equipment requirements and techniques for neuro-otendoscopy. A brief super-VHS videotape of intraoperative endoscopic images is presented, demonstrating normal anatomy as well as a range of pathological conditions including acoustic neuroma, cerebellopontine angle epidermoid, meningioma and petrous apex cholesterol granuloma.

HISTOPATHOLOGY OF THE BINAURAL COCHLEAR IMPLANT SUBJECT

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Binaural hearing improves speech reception in noise, and is necessary for sound localisation. Normal hearing subjects use both interaural time, and intensity, differences
ABSTRACTS

Jugular foramen tumours are uncommon but challenging situations for the patient and surgeon alike. These tumours are clinically silent, until symptoms are present due to Neuraxial nerve compression or the presence of a brainstem artery aneurysm. These tumours were classified as either acoustic neuroma, or neurofibromatosis type 2 (NF2) schwannomas, and meningeal. The series consists of 400 cases of jugular foramen tumours and 20% were other malignancies. The surgical approach was performed via the lateral otological skull base approach or middle cranial fossa. The surgical results of 40 consecutive patients (90%) have House grade I or II function at six weeks post-operatively. Two patients are currently at grade V, and 1 is grade VI.

Postoperative complications included CSF leaks, a case of meningitis, deep vein thrombosis and probable minor cerebellar cerebrovascular accident. These are detailed and discussed.

Finally, the audiometric results of patients who underwent attempted hearing preservation are presented.

NEUROFIBROMATOSIS TYPE 2: THE 15-YEAR CAMBRIDGE EXPERIENCE

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Neurofibromatosis type 2 (NF2) is one of the most formidable human genetic conditions. Bilateral vestibular schwannomas are the hallmark of this disorder. Cerebellopontine angle and other central nervous tumours give rise to cranial and spinal neuropathies.

Despite significant advances in microsurgery, neuroanaesthesia and magnetic resonance imaging, the morbidity of this disease has not been dramatically reduced. Currently, prevention of NF2 is possible only by its early detection and genetic counselling.

The 15-year experience in the diagnosis and management of NF2 at a tertiary referral neurotological unit is presented. Twenty-nine consecutive patients with NF2, presenting between 1984 and 1999 were reviewed. In these patients, there was a total of 51 cerebellopontine angle tumours, which included 48 vestibular schwannomas. In the series, details of the presentation, treatment and the outcome of these NF2 patients were...
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