factors including age, location of the defect, and surgeon's preference. In this case-based presentation, the challenges of diagnosing and managing CSF leaks and encephaloceles will be discussed. Advantages and disadvantages of imaging modalities will be compared. Finally, surgical approaches including middle fossa craniotomy, transmastoid, and combination approaches will be examined.

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Management of difficult cases (R861)

ID: 861.4

The surgical management of temporal bone cholesteatoma involving into jugular foramen

Presenting Author: **Chunfu Dai**

Chunfu Dai

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Learning Objectives: To share surigical experiences on management of temporal bone cholesteatoma invovling into jugular foramen.

Cholesteatoma involves into jugular foramen are rare. Clinical findings such as symptoms, signs, and preoperative hearing are frequently nonspecific in cases of temporal bone cholesteatoma, the surgical removal of cholesteatoma in this region is great challenge for the skull base surgeons. Eighteen cases with temporal bone cholesteatoma involving into jugular foramen were operated, the surgical approaches, intraoperative findings, surgical outcomes were retrospectively reviewed in the present study.

Eight cases are female, 10 cases are male, 8 cases in the left side, 10 in the right. The age ranges from 26-68 years old. The symptoms included hearing loss (17/18), otorrhea (8/18), pulsatile tinnitus (7/18), headache (2/18). Ten patients complained of facial paralysis, no patients suffered from the dysfunction of lower cranial nerves. All patients were undergone infratemporal fossa approach with facial fallopian canal bridge technique, Jugular foramen was erossion in all 18 cases, horizontal segment of ICA was encroached in 6 cases, sigmoid sinus and posterior fossa were compressed in 17 case. The clivus was destructed in 2 cases.

Facial nerve intact was remained in 6 patients , cable graft was conducted in 2 patients, facial hypoglossal nerve anastomosis was performed in two patients. Intraoperatively CSF leakage was incurred in 9 patients, sigmoid sinus or jugular bulb erupted in 3 cases, and sigmoid sinus occlusion with jugular vein ligation was undertaken. Eustachian tube was packed with temporal muscle and bone wax, the surgical cavity was packed with abdominal fat, blind sac closure was conducted in all patients. No major complications was observed.

Infratemporal fossa approach with facial nerve canal bridge technique is good option for patients with cholesteatoma involving into jugular foramen, which is sufficient to remove the lesion and control the vessels, as well to preserve facial nerve function.

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Free Papers (F862)

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Smoking does not influence the take rate of transcanal endoscopic tympanoplasty

Presenting Author: **Wu-Po Chao**

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Learning Objectives: To evaluate the anatomical and audiological outcomes of transcanal endoscopic tympanoplasty with patient who has smoking habbit, and to those who do not.

Smoking does not influence the take rate of transcanal endoscopic tympanoplasty.

Objective: This study is aimed to evaluate the anatomical and audiological outcomes of transcanal endoscopic tympanoplasty with patient who has smoking habbit, and to those who do not.

Material and method: We had retrospectively reviewed the patients who had tympanic membrane perforation and underwent transcanal endoscopic tympanoplasty in Chang-Gung Memorial Hospital. After the surgery, the follow-up reperforation rate and audiologic test will be used to evaluate the take rate of the surgery between smoking and non-smoking group. All calculation were performed with a commercial statistical software package(SPSS 12.0 for windows).

Results: The result showed the take rate of transcanal endoscopic tympanoplasty between smoking and non-smoking group was 89% and 86% respectively.

Conclusion: It seems that smoking maybe an important factor to the patient with otitis media. However, it may not influence the outcome of take rate post-operatively. We will present our data and discuss on the conference.

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Free Papers (F862)

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Preliminary outcomes of endoscopic middle ear surgery, our UK experience

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