well as review those technical factors that are critical for successful outcomes.

Methods: Patients (n = 240) that underwent subtotal petrosectomy with closure of the external auditory canal and obliteration of the cavity with abdominal fat for various presentations of cholesteatoma were analyzed.

Results: The most frequent indication for subtotal petrosectomy was in recurrent disease, previous radical cavities, in petrous bone cholesteatomas and in meningoencephalic herniations. Recurrence of cholesteatoma was seen in only 4 (1.7%) cases. Other minor postoperative complications like wound dehiscence and infection of fat in the cavity etc occurred in 13 patients (11.83%).

Conclusions: Subtotal petrosectomy permits obtaining a cavity isolated from the external environment, and when needed, it improves the access and visibility during the surgical procedure. Subtotal petrosectomy is a safe technique, with a low rate of complications.

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How do we approach cholesteatoma (N613)

ID: 613.4

Tips and tricks in Open Tympanoplasties

Presenting Author: **Enrico Piccirillo**

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Gruppo Otologico

Learning Objectives: To evaluate the outcomes of open tympanoplasties (canal wall down mastoidectomies) for cholesteatomas.

Study Design: Retrospective study.

Setting: Gruppo Otologico, a quarternary referral center for Otology and Skull Base Surgery in Italy.

Methods: 1324 cases with a minimum of 2-years follow-up that were operated for middle ear and mastoid cholesteatoma using the open technique were included in the study. The outcomes of were analyzed and the results were compared with a literature review.

Results: The mean follow up was 46.43 months. The mean pre-operative air bone gap was 37 ± 7 dB. Simultaneous ossicular reconstruction was performed in 32% of the cases. A second stage reconstruction was perfomed in 42% of the cases. Recurrent cholesteatomas were seen in 6% of cases in our series. 1% patients developed stenosis of the meatoplasty. Postoperative ear discharge was observed in 4% cases.

Conclusion: The open (canal wall down) technique is a tried and tested procedure in recurrent and large cholesteatoma with considerable pre-operative hearing loss.

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Evidence based practice in Cholesteatoma Surgery (R614)

ID: 614.1

What do we do in the absence of evidence?

Presenting Author: **Iain Swan**

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Modern medical practice should be based on evidence, but often in surgery we have little evidence for our surgical practice. Traditionally surgeons have relied on what they have been taught by their trainers or read in textbooks. The main source of information nowadays is the published literature but, in surgery, this is usually case series which is level 5 evidence. This raises several questions:

Are my patients comparable?

Do I have the skills to achieve these outcomes?

Has the surgeon included all the patients in the results?

The only results that you can rely on are your own. But human memory is selective and we tend to forget our poor results and remember the good ones. To reliably assess our own results requires audit. All surgeons should prospectively audit their own results. Using an established audit database is the most practical way to do this as others have already decided the most useful data to collect. Your data should be reviewed regularly, and results of your audit should be reported each year at your annual appraisal.

Auditing your own results allows you to compare your outcomes with those of other surgeons and tells you what is working and what needs improving.

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Evidence based practice in Cholesteatoma Surgery (R614)

ID: 614.2

Canal wall up versus canal wall down mastoidectomy for acquired cholesteatoma; a systematic review on disease recurrence rates

Presenting Author: **Jef Mulder**

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Learning Objectives: The aim of this study is to compare the proportion of disease recurrences in patients with acquired cholesteatoma, 5 years after Canal Wall Up or Canal Wall Down mastoidectomy.

Introduction: Cholesteatoma is a destructive ear disease. Therapy consists of surgical removal by mainly the canal