

**Material and Methods:** A randomized, longitudinal study took into consideration the Stage II RP that were either treated by a surgical procedure or simply observed for a period of two years. Surgery consisted in an endaural approach epitympanectomy with scutum reconstruction (tragal cartilage).

**Results:** All the operated cases showed a permanent healing condition with stable hearing function. Nearly half of the “observation group” showed instead deepening of the pocket that in one case even ended up with perforation. In none of the study patients a real cholesteatoma was observed.

**Conclusions:** A preventive surgery is to be preferred in all Stage II RP. In fact, even if in some of the patients it could remain stable over the time taken into consideration (2 years), the possibility of occurrence of a more severe stage, ending up potentially to cholesteatoma, would represent a reasonable choice in order to avoid in the future more complex surgical procedures and all related possible complications.

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### Labyrinthine problem in chronic ear diseases (R864)

**ID: 864.1**

#### Cholesteatoma with canal fistula and the third mobile window

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**Learning Objectives:** The better bone conduction threshold at low-tone frequencies immediately after tympanoplasty with mastoidectomy and no preoperative fistula symptoms might imply the third mobile window theory. The worse bone conduction threshold in high-tone frequencies with spontaneous nystagmus after surgery might indicate inner ear damage.

**Objective:** To understand the third mobile window effect of chronic otitis media with cholesteatoma with inner ear fistula on the bone conduction threshold, we examined changes in the bone conduction audiogram after tympanoplasty with mastoidectomy for chronic otitis media with cholesteatoma with canal fistula.

**Study Design:** Retrospective case review.

**Patients:** According to the intraoperative classification of Dornhoffer and Milewski, we focused especially on type IIa (anatomical bony fistula with no perilymph leak). We checked the bone conduction threshold at least three times: just before, just after, and 6 months after surgery in 20 ears with type IIa lateral semicircular canal fistula.

**Results:** Compared with the preoperative bone conduction threshold, six cases were better, 12 cases were unchanged, and two cases were worse within the first postoperative week. Finally, one case was better, 15 cases were unchanged, and four cases were worse at the sixth postoperative month.

Patients with a better bone conduction threshold in the low-tone frequencies immediately after surgery had a tendency to show no preoperative fistula symptoms. Postoperative spontaneous nystagmus had a tendency to be observed in patients with a worse bone conduction threshold in the high-tone frequencies.

**Conclusion:** The better bone conduction threshold at low-tone frequencies immediately after tympanoplasty with mastoidectomy and no preoperative fistula symptoms might imply the third mobile window theory. The worse bone conduction threshold in high-tone frequencies with spontaneous nystagmus after surgery might indicate inner ear damage.

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### Labyrinthine problem in chronic ear diseases (R864)

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#### The surgical management of labyrinthine fistula in chronic ears

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**Learning Objectives:** This presentation will explore the identification, surgical management and outcome of labyrinthine fistula in the presence of chronic ear disease. The format will use real patient scenarios and intra-operative video to illustrate the learning points.

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### Labyrinthine problem in chronic ear diseases (R864)

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#### Staging method for cholesteatoma-induced semicircular canal fistula using CTP (Cochlin tomo-protein), as a diagnostic marker

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