EXTERNAL AUDITORY CANAL
EXOSTOSES
EAC EXOSTOSES
Clinical Aspects

- Solitary or multiple
- Benign bony tumours
- Develop with exposure to cold water
- Gradually occlude the EAC
- May recur over many years
Exostoses of the EAC. The lesions are usually multiple, in the deep canal, and associated with a history of cold water sports or occupation.
Solitary exostosis on the scutum, approximate to the handle of the malleus.
Small exostosis on the deep anterior right EAC wall.
Solitary exostosis on the scutum at 9 o’clock with protrusion into the middle ear.
Pea-shaped pedunculated exostosis of the deep left EAC at 12 o’clock. Superficial to the malleus and asymptomatic. An anterior wall lesion is gradually developing.
A large exostosis of the anterior canal wall, filling half the EAC lumen.
A large solitary exostosis causing debris accumulation, blockage and deafness, requiring removal. Delicately chiselling the thin pedicle achieves a simple removal.
Dual pedunculated lesions on the deep attic wall. Innocuous and left unmolested.
Typical occlusion of the canal by inferior sessile type exostoses. The masses gradually coalesce, restricting the deep EAC lumen.
Similar view showing advancing coalescence of the masses, steadily reducing the available skin in the canal.
Gross blockage of the canal by advanced lesions, but without coalescence inferiorly. Clearance of one or the other will greatly facilitate removal of the remainder.
Severely narrowed EAC by non-coalescing lesions. Low grade infection is present and likely to continue and worsen.
Gross occlusion, exacerbated by debris occlusion in the deep canal. Persistent blockage and intermittent infection are probable.
Removal of exostoses by a trans-canal approach. The skin over the lesions is carefully elevated, then the bony masses are hollowed out and the shells removed carefully.
Removal of Rt exostoses. Surgeon’s view from behind, patient recumbent. The canal skin has been elevated off a large postero-inferior sessile lesion. This will be hollowed out.
The exostosis has been exenterated and the overlying skin detached intact. The remaining shell is being withdrawn from the canal.
A 12 o’clock pedunculated lesion has been removed by skin elevation, then diamond drilling the pedicle to detach the lesion.
Complete removal of the exostoses is followed by replacing the skin to cover all the bare surfaces. Retention of the canal skin and careful resiting are critical to the surgery.
End result with the intact drum viewed via an adequate EAC lumen.
Post exostoses removals. Preservation of the canal skin to cover the drilled surfaces minimises postoperative infection and promotes healing that should be complete in 4-5/52.
Recurrent exostoses, 25 years later. Lifelong surfer. The multiplicity of lesions are seen coating the canal wall. Similar problems may occur in congenital ear canalplasties.
EAC EXOSTOSES

Summary

- Solitary or multiple
- Multiple patterns are secondary to cold water immersion
- Remove if troublesome; ensure skin retention
- May recur after many years