Sessile tumour of the left cerebello-pontine angle.
Meningioma.
Histiocytosis X. Axial CT. Gross osteolytic destruction of the left mastoid and middle ear.
Previous case, coronal CT view demonstrating the erosion of the left temporal bone. Unlike cholesteatoma, the erosion is “moth-eaten’ rather than circumscribed.
A large fibroma of the right infra-temporal fossa.
Asymptomatic.

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Axial CT views of the previous case. Extensive filling defect in the right infra-temporal fossa.
Transitional cell carcinoma presenting in the left EAC. The primary site was in the postnasal space, extension via the Eustachian tube into the middle ear.
Squamous cell carcinoma in the left EAC. The fleshy mass is dissimilar to the aural polyps found secondary to cholesteatoma formation.
Squamous cell carcinoma occluding the left EAC. The swollen and bulging canal skin betrays the nature of the tissue mass.
Squamous cell carcinoma, right EAC. Diffuse spread mandated a subtotal petrosectomy and canal-closure ablation.
Cerebellar and brainstem glioma in a case that presented with non-fatiguing positional vertigo.
Meningioma of the left cerebellopontine angle. There is hyperostosis evident and a spherical well defined lesion with a contrast-enhancing margin.
Giant exostosis of the tympanic plate. Prior surgery has occluded the EAC; a substantial inclusion cholesteatoma has resulted.
Extensive fibrous dysplasia of the right temporal bone, extending across the skull base. A wide meatoplasty was required to restore hearing but the middle ear was unaffected.
Previous case, lower cut axial CT. Gross bony involvement.
Fibrous dysplasia, right temporal bone and adjacent structures. Total canalplasty used to core-out the soft bony occlusion of the EAC, followed by split skin grafting.
Further detail of the previous case showing little middle ear involvement.
Same case, further detail of the middle ear.
Fibrous dysplasia, left temporal bone. Extension into the sphenoid and pterygoids.