MEATOPLASTY AND CANALPLASTY

Outcomes
Large, misshapen and triangular canal orifice. Previous endaural mastoidectomy surgery.
Elongated canal entrance enlargement secondary to a Korner-type meatoplasty. Orifice size and shape is difficult to judge from a post-aural approach.
Extensive resection of the conchal bowl cartilage. Undertaken to permit access to an open mastoidectomy cavity.
A very large and unsightly EAC secondary to a conchal bowl flap rotation (scar evident in the inferior bowl) in the course of a postaural radical mastoidectomy,
A misshapen meatoplasty outcome secondary to removal of the cymba conchae and antero-superior conchal bowl. An open cavity is evident via the EAC.
Subtotal mastoidectomy-related conchal bowl removal resulting in considerable auricular disfigurement.
Giant meatoplasty. Unnecessary.
Canal enlargement for post-radiation chronic otitis externa. A larger entrance was created to minimise humidity. The tragus had necroosed previously.
A post-Hunsaker meatus. This method allows an accurate assessment of the final intoitus diameter, and avoids unsightly conchal bowl disfigurement.
Hunsaker meatoplasty. The semicircular anterior conchal bowl incision line can be discerned at the rim.
Post canalplasty, mid-canal section. After an SSG procedure the canal requires cleaning on a 6-12/12 basis. Neglecting this carries a risk of keratin accumulation and infection.
Deep EAC and drum view, the latter featureless due to fine fibrotic changes.
Lt EAC after total canalplasty with SSG throughout. Mid-canal view.
Deeper canal view. Mild dry keratin accumulation. This usually peels out in fine layers.

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