Cholesteatoma

see Epidermoid cyst.

Cholesteatoma and epidermoid cysts are not the same, although they share some similarities in that they both involve the accumulation of keratinized skin cells. Here's how they differ:

Location:

Cholesteatoma: Cholesteatomas are typically found in the middle ear and may also extend into the mastoid bone behind the ear. They are often associated with chronic ear infections or other ear-related issues. Epidermoid Cyst: Epidermoid cysts can occur in various parts of the body, including the skin, but they are not specifically associated with the middle ear or ear-related problems. They can develop in other areas as well. Origin:

Cholesteatoma: Cholesteatomas usually develop as a result of abnormal skin growth behind the eardrum, often due to chronic ear infections or other ear-related conditions. They are typically composed of keratinized skin cells. Epidermoid Cyst: Epidermoid cysts are generally congenital (present at birth) or can develop later in life. They are also formed by the accumulation of keratin and skin cells, but they are not directly related to ear infections. Clinical Implications:

Cholesteatoma: Cholesteatomas can be problematic because they can erode bone and potentially lead to hearing loss, dizziness, and other complications if left untreated. Surgical intervention is often necessary to remove them. Epidermoid Cyst: Epidermoid cysts are generally benign and do not typically cause severe health issues. However, they can become inflamed, infected, or painful, which may require medical attention or removal. In summary, while both cholesteatomas and epidermoid cysts involve the accumulation of skin cells, they differ in terms of location, origin, and clinical implications. Cholesteatomas specifically pertain to the middle ear and are associated with ear-related problems, whereas epidermoid cysts can occur in various parts of the body and are not necessarily related to ear health. If you suspect you have a medical issue like this, it's essential to consult with a healthcare professional for proper diagnosis and treatment.

Cholesteatoma is a well-demarcated cystic lesion derived from an abnormal growth of keratinizing squamous epithelium in the temporal bone. Cholesteatomas commonly involve the middle ear, epitympanum, mastoid antrum, and air cells and can remain within these confines for a considerable period. Bony erosion is presently confined to the ossicular chain and scutum initially, but as the cholesteatoma expands, erosion of the otic capsule, fallopian canal, and tegmen can occur. Erosion of the tegmen tympani or tegmen mastoideum may lead to the development of a brain hernia or cerebrospinal fluid leakage. Invasion of the jugular bulb, sigmoid sinus, and internal carotid artery are noticed in extensive cholesteatoma and are quite challenging and require expertise. Neurosurgical intervention should be considered along with otological management in the same sitting in all possible cases. A retrospective review of 12 patients was carried out to assess the clinical presentation, complications, surgical management, and postoperative outcomes of extensive cholesteatomas presenting at our center between January 2017 and December 2019. CT or MRI findings, the extent of cholesteatoma intra-operatively along with the status of major neurovascular structures and disease clearance, and the post-operative outcomes including morbidity and mortality

were noted. All patients underwent canal wall down mastoidectomy with or without ossiculoplasty. Postoperatively all patients were treated with intravenous antibiotics and if required intravenous steroids. Amongst the 12 patients with extensive cholesteatoma (EC), all of them (100%) presented with foul-smelling, purulent ear discharge. 9 (75%) patients presented with otalgia. 4 (33.33%) patients had temporal headache. 10 (83.33%) patients complained of hard of hearing. 7 (58.33%) patients give a history of vertigo at the time of presentation. In 8 (66.66%) patients there was tegmen plate erosion noticed in CT scan. In 3 (25%) patients, the disease was invading the sigmoid sinus and in 1 (8.33%) patient jugular bulb was involved. In 3 (25%) cases of EC, blind sac closure was performed. In two patients who developed a cerebellar abscess, a drainage procedure was performed. 2 (16.66%) patients developed sigmoid sinus thrombosis, 1 (8.33%) patient had petrositis [1].

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Prasad KC, Vyshnavi V, Abhilasha K, Prathyusha K, Anjali PK, Varsha GI. Extensive Cholesteatomas: Presentation, Complications and Management Strategy. Indian J Otolaryngol Head Neck Surg. 2022 Aug;74(Suppl 1):184-189. doi: 10.1007/s12070-020-01948-0. Epub 2020 Jul 9. PMID: 36032932; PMCID: PMC9411359.