

Bony Obliteration Course Antwerp 2026

Recently, I had the opportunity to travel to Antwerp to attend a course focused on bony obliteration techniques in the surgical management of middle ear cholesteatoma. As someone with a large cholesteatoma workload, the course provided an invaluable combination of practical surgical tips, evidence-based discussion, and exposure to the experience of surgeons who have extensively adopted mastoid obliteration techniques. Beyond learning specific technical skills, the course encouraged me to reflect on my own practice, particularly regarding disease staging, outcomes assessment, and strategies to reduce residual and recurrent cholesteatoma.

One of the most important lessons I took away was the importance of routinely staging cholesteatoma using the EAONO/JOS consensus classification. While staging systems can sometimes feel academic and detached from everyday clinical work, the course highlighted their practical value. Consistent disease staging allows meaningful comparison of outcomes, both at an individual surgeon level and across departments. It also provides a robust framework for future research and audit projects. Reflecting on my own practice, I recognise that adopting a formal staging system will help me better understand my residual and recurrent disease rates and identify areas where surgical outcomes could potentially be improved.

The practical aspects of mastoid obliteration were particularly valuable. I learned techniques for harvesting bone chips using a 2 cm Lambotte osteotome and for collecting autologous bone dust using the Osteotrap system. These may seem like small technical details, but they are crucial steps in creating a reliable obliteration construct. There was a helpful discussion around the importance of rinsing collected bone dust, ideally with rifampicin, and the role of postoperative antibiotics in selected cases, particularly when infection is present or in paediatric patients, where the risk of infecting the obliterated cavity may be higher.

Several useful technical pearls were shared regarding reconstruction. The use of Otomimix to secure bone chips was demonstrated, with emphasis on ensuring an extremely dry field and avoiding application directly over a dehiscence of the facial nerve. The role of Tisseel as an adjunct in reconstruction was also discussed. Additionally, I was introduced to BonAlive, a synthetic bone substitute that can be used laterally over the mastoid cavity when autologous bone dust has been compressed medially. This appears to offer several practical advantages and may reduce the need for additional tissue harvest. Alternatively, some centres use it as a complete substitute for bone dust.

Another particularly interesting topic was the use of Mesna as a mucolytic agent during cholesteatoma surgery. Allowing Mesna to dwell on retraction pockets and adherent epithelial tissue can facilitate safer dissection and removal of disease. This is a

technique I have not routinely employed, and I can see situations where it may be especially useful in difficult cases with extensive retraction pockets.

The course also reinforced the importance of careful preoperative imaging assessment. We had a useful discussion around the recommendation to obtain gadolinium-enhanced MRI in cases with lateral semicircular canal dehiscence. Enhancement suggests that the labyrinth remains viable rather than fibrosed, identifying patients who may be at risk of profound hearing loss if surgery disturbs the inner ear. This highlighted how detailed radiological assessment can directly influence surgical planning and risk counselling.

The evidence presented regarding mastoid obliteration was compelling. Traditional canal wall up surgery has been associated with reported residual or recurrent cholesteatoma rates ranging from 10% to 60%, whereas studies examining primary obliteration techniques suggest rates closer to 5%. While patient selection and study methodology undoubtedly influence these figures, the data support the growing view that obliteration may significantly improve long-term disease control. This prompted me to reflect on how I evaluate surgical success and the importance of tracking outcomes systematically within my own practice.

The imaging discussions were equally informative. Particular attention was given to the interpretation of non-echo planar diffusion-weighted MRI, including the importance of assessing signal characteristics across multiple sequences. An especially useful learning point concerned epineural pseudocysts of the facial nerve, which can mimic cholesteatoma on diffusion-weighted imaging. Understanding their typical location posterior to the descending facial nerve, alongside their characteristic signal intensity on T1-weighted imaging, provides valuable insight when interpreting postoperative surveillance scans.

The course also provided numerous practical tips regarding blind sac closure techniques. These included modifying the canal transection in patients who have previously undergone a modified radical mastoidectomy to maximise available skin for closure, creating an anteriorly based periosteal flap to provide an additional closure layer, and using a combination of bipolar cautery, periosteum, bone wax, and Tisseel to seal the Eustachian tube. The use of BonAlive as an alternative to abdominal fat grafting was particularly appealing, potentially avoiding donor-site morbidity while providing a stable, non-resorbing obliteration material.

Finally, I learned about the middle temporal artery periosteal flap and the importance of careful flap design. Understanding the vascular anatomy, identifying the vascular “tram lines,” and ensuring that incisions are positioned to preserve the arterial supply are all crucial to successful flap elevation and reconstruction. These are technical details that

are difficult to appreciate fully from textbooks alone and were greatly enhanced by observing experienced surgeons explain their rationale and technique.

Overall, the Antwerp bony obliteration course was an extremely valuable educational experience. It provided practical surgical techniques that I can incorporate into my own practice, while also encouraging broader reflection on disease staging, outcome measurement, imaging interpretation, and evidence-based decision making. Perhaps most importantly, it reinforced the importance of continually evaluating and refining surgical techniques in pursuit of better long-term outcomes for patients with cholesteatoma. I returned with not only new technical knowledge but also a greater appreciation of the systematic approaches required to improve both individual and departmental practice.

Beyond the educational value of the course, one of the most rewarding aspects was the opportunity to meet and learn from colleagues working in different healthcare systems across Europe and beyond. Informal discussions often proved just as valuable as the formal teaching sessions, providing insight into variations in surgical technique, patient pathways, training structures, and approaches to balancing professional and personal life. The faculty and local team were exceptionally welcoming hosts, creating an environment that encouraged open discussion and collaboration. The course dinner was a particular highlight, offering time to reflect on the day's learning, exchange experiences with fellow delegates, and build new professional connections. There was also the opportunity to explore the beautiful city of Antwerp, whose rich history and culture provided a wonderful backdrop to the course. A personal highlight was visiting the [Plantin-Moretus Museum](#), a fascinating museum and UNESCO World Heritage site that offers a unique insight into the history of printing and publishing. Overall, the combination of excellent teaching, collegial discussion, and cultural experience made the trip both professionally enriching and personally memorable, and I would highly recommend the course to anyone with an interest in cholesteatoma surgery and mastoid obliteration techniques.