Squamous carcinoma is the most frequent neoplasm in the external auditory canal (EAC), about four times more common than basal carcinomas.

Most squamous cell carcinomas (SCC) of the temporal bone occur in the fifth and sixth decades of life. Otorrhea is the primary symptom, and otalgia, hearing loss, and bleeding may be frequent as well. Diagnosis is usually delayed because symptoms are quite similar to other benign otologic conditions such as chronic supplicative otitis media.

These tumors have an aggressive nature and spread along preformed vascular and neural pathways, invading adjacent structures. Treatment usually combines surgery with free margins and radiotherapy. Surgery alone may be used for very early stages (T1), whereas radiotherapy alone is rarely used.

**Histologic Types of External Auditory Canal (EAC) Cancer**
- Squamous cell carcinoma (SCC) (86%)
- Basal cell carcinoma (BCC) (6%)
- Adenoid cystic carcinoma (6%)
- Adenocarcinoma (2%)
- Melanoma (1%)
- Acinic cell (<1%)
- Merkel cell (<1%)

Signs
- Canal mass (88%)
- Aural drainage (84%)
- Periauricular edema (25%)
- Facial paralysis (18%)
- Neck nodes (8%)
- Temporal mass (8%)

Symptoms
- Pain (74%)
- Hearing loss (62%)
- Pruritis (40%)
- Bleeding (18%)
- Headache (18%)
- Tinnitus (18%)
- Facial numbness (12%)
- Vertigo (12%)
- Hoarseness (4%)

**Staging**
- T1: tumor limited to the EAC without bony erosion or soft tissue extension

These tumors have been associated with chronic supplicative otitis media and exposure to chemicals, though the most important factor may be previous radiotherapy.

**Indications**
- Resection en bloc of neoplasm involving the EAC

**Clinical Case**

The elderly patient with otorrhea and right ear, nearly permanent, hearing loss for about a year. The patient was misdiagnosed and treated in this interval as for an otitis externa. At the time of our appointment in our Otolaryngology service, the patient presented otorrhea, hearing loss, and the otomicroscopic examination in 1/3 distal of the external auditory meatus, revealed an infiltrative and vegetative formation with postero-inferior insertion and distal channel obliteration.

The MRI exam, highlighting a space replacement process, with about 7mm on the long axis of the CAE it is molding and about 8mm on the cranial-caudal axis. at the inner level of the distal third of the external auditory channel, which respeparticularity of this case is, first of all, the late detection of the tumor formation or rather its non-recognition of "specialty colleagues" who treated it as a mere otitis externa; rapid development in development (8 months of patient narratives), observance of the CAE bone canal, tympanic membrane lysis and maleus erosion.

The complete excision of the tumor formation was performed by the posterior approach (Portmann incision) with the underlying milling of the external auditory canal postero-inferior and internal. Evidence of tympanic perforation with erosion of the hammer handle, forced Type 2 Timpanoplasty with aponeurosis of temporal muscles and fragment of cartilage tragal.

The histopathological outcome was differentiated carcinoma. Immediate post-surgical evolution, then at 1, 2, 3 and 5 months, was favorable with the perfect integration of neotimpan. The patient is externalized and is directed to the oncology service.

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