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MOZART EAR: A RARE DEFORMITY OF THE AURICLE

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Abstract

Introduction. Congenital auricular anomalies are observed in approximately 30% of newborns and represent the most frequent craniofacial defects, with an overall incidence of 1 in 6000 live births; 15-20% resolve spontaneously. If diagnosed early, most such deformities can be corrected conservatively by splinting; after the neonatal period surgery is usually required. Mozart ear is a rare deformity characterized by inversion of the cavum conchae with a slit-like narrowing of the external auditory meatus.
Aim. To present a rare case of surgical treatment of Mozart ear and describe the modified technique, intraoperative challenges and short-term results.
Materials and methods. A 23-year-old male presented with a unilateral inverted right auricle and slit-like stenosis of the external auditory meatus identified in early childhood, accompanied by cerumen impaction and difficulty retaining in-ear headphones. Under general anaesthesia, correction of the cavum conchae was performed, comprising resection and reversal of the conchal cartilage, its re-implantation as a free graft, and enlargement of the meatus with Mustardé sutures. The postoperative course was uneventful.
Results. Improvement of the auricular contour was evident within the first postoperative week, and an optimal concave shape with a widened meatal opening was achieved by one month. During 6 months of follow-up the correction remained stable, posterior symmetry was restored, comfortable use of headphones was regained, and the patient was satisfied with the outcome.
Conclusions. Mozart ear is a rare deformity causing primarily aesthetic and, occasionally, functional concerns. Early diagnosis allows non-surgical management; after the neonatal period surgery remains the option of choice. The procedure should be tailored to the severity of the deformity and the patient's expectations.

Keywords: **ear anomaly, conchal deformation, concave concha, surgical correction**

INTRODUCTION

It is a peculiar irony of fate that the man whose inner ear has, so to speak, the highest human development has a retarded and malformed outer ear.
GERBER, 1898

Congenital auricular abnormalities are relatively common and affect the normal shape and structure of the external ear. These conditions are generally divided into malformations and deformities. Malformations, such as microtia, anotia, and cryptotia, are caused by problems in ear development during early pregnancy. They usually arise between the 5th and 9th weeks of gestation, when the main parts of the auricle are forming. As a result, the ear may be partially formed, underdeveloped, or absent.

Deformities, in contrast, occur when the ear is fully formed but develops an abnormal shape. This happens when external forces, such as pressure in the womb or after birth, affect the normal position or folding of the auricle. Deformities may develop at any time during pregnancy or in the postnatal period [5]. Understanding the difference between malformations and deformities is important for choosing the most appropriate treatment, as malformations often require surgical correction, while deformities may be managed with early, non-surgical methods.

The overall incidence of external ear anomalies is 1 in 6000 newborns, making this pathology the most frequent among craniofacial defects (Brent, 1999). Approximately 30% of newborns exhibit varying degrees of deformity, of which 15-20% resolve spontaneously

over time [2, 3]. Auricular deformities include lop ear, helix deformities, Stahl's ear and Mozart ear.

Mozart ear, also known as an inverted auricle, is a rare auricular deformity, with only a few cases described in existing medical literature. According to Yamashita et al. (2011), Mozart ear is characterized by a protrusion of the anterosuperior part of the auricle (scafa), a convex cavum conchae, and a slit-like narrowing of the external auditory meatus [19]. Some authors describe this anomaly as a fusion of the antihelix with the helix.

This pathology may be present unilaterally or bilaterally. Although rare, it has been known to cause both aesthetic and functional concerns. Potential dysfunctions include conductive hearing loss, cerumen impaction, and difficulties or inability to use in-ear headphones (earbuds), earplugs for noise reduction, or similar accessories. Treatment options for this condition range from conservative approaches, such as neonatal ear molding and splinting [9, 10, 12, 13, 16], to various surgical techniques [1, 6, 8, 15, 19]. The neonatal ear cartilage is soft and malleable. So reshaping of deformed cartilage is easy. This condition is related to high levels of hyaluronic acid and free estradiol during the first three days after birth. After the neonatal period, the ear cartilage becomes stiffer and less malleable. In children beyond the early neonatal period, success rates with nonsurgical correction are about 50%. Inverted concha deformity causes aesthetic and functional problems. In the neonatal period, splinting is a simple, safe and effective treatment option. If diagnosed early, most such deformities can be treated conservatively with splinting, which typically produces favourable results [14]. After the neonatal period, it can be corrected with surgical techniques successfully. The technique of surgery is dependent on the experience of the surgeon. To date, there are no definitive approaches to treating this pathology, which is why solving this problem is relevant from a scientific and practical point of view.

AIM

To present a rare congenital anomaly known as Mozart ear and to describe the surgical technique, including the rationale for the chosen treatment strategy, details of the modified surgical technique, intraoperative challenges and both immediate and short-term clinical results.

MATERIALS AND METHODS

Here we describe our case. A 23-year-old male patient presented to our clinic with a unilateral inversion of the concha, detected in early childhood. According to the patient, there was no family history of auricular deformities. Diagnostic examination revealed unilateral inversion of the concha, flattening of the antihelix and a slit-like external auditory canal entrance (Figures 1, 2). The external auditory canal was significantly narrowed due to the convexity of the concha. During consultation, the otolaryngologist found cerumen accumulation within the canal and removed it. The patient expressed concerns about his asymmetrical auricles since the left ear exhibited well-defined anatomy and a patent external auditory canal. He also reported difficulty using earphones on the right side. Functional complaints were limited to the right ear, whereas no additional auricular or facial deformities were noted. Other external ear structures, including the helix, antihelix, tragus, antitragus, and lobule, were normally developed. Examination of the middle and inner ears was unremarkable bilaterally. No other systemic signs or symptoms were observed. The patient merely sought surgical correction of the right auricle and widening of the right external auditory canal.

Figure 1. Rear view. Pre-surgical examination.

Figure 2. Side view. Pre-surgical examination.

Following the examination, the patient underwent surgical correction of the cavum conchae, performed under general anaesthesia. Preparatory steps involved preoperative marking of the convex cartilage and administering local infiltration anaesthesia. Next, an incision was made in the skin along the posterior surface of the auricle. The surgical procedure required resection

of the conchal cartilage, its reversal, and reinsertion as a free graft, after which the cartilage was secured in its new position using mattress sutures. Enlargement of the external auditory canal was achieved with Mustardé sutures. Finally, skin closure was performed with 4-0 Vicryl. A non-adherent gauze dressing was applied over the newly formed auricular cavity, and the external auditory canal was lightly packed. The postoperative course was uneventful.

RESULTS

The patient attended follow-up appointments at 1 and 3 months postoperatively. Improvement was evident as early as the first postoperative week, while an optimal contour was achieved after one month. Examination revealed an adequately concave auricle with a wide external auditory canal opening (see postoperative photographs at 1 and 3 months) (Figures 3, 4, 5). The correction restored posterior symmetry, a lack of which had been a source of aesthetic concern to the patient, and enabled comfortable use of in-ear earphones. The patient's condition was monitored for 6 months, during which the correction remained stable. No complications were reported, and the patient was satisfied with the outcome.

Figure 3. Rear view, 7 days after surgery.

Figure 4. Right auricle, 7 days after surgery.

Figure 5. Right auricle, 1 month after surgery.

DISCUSSION

Although the external ear plays a limited role in hearing, deviations from the typical shape or position are readily visible and may cause substantial psychosocial burden. The auricles also serve practical functions such as supporting eyeglasses and hearing aids and are a common site of aesthetic adornment.

The external ear, also called the auricle or pinna, is made of elastic cartilage covered by skin. It contains skin, cartilage, and a small group of intrinsic and extrinsic muscles that help maintain its shape and position.

Development of the external ear occurs early in pregnancy. Between the fourth and ninth weeks of gestation, the auricle, external auditory canal, and middle ear develop from tissues of the first and second branchial arches. The final shape of the auricle is formed by six small mesenchymal swellings, known as the hillocks of His, which appear around the first branchial cleft. Hillocks one to three arise from the first (mandibular) arch, while hillocks four to six arise from the second (hyoid) arch.

Disturbances in this developmental process can lead to congenital ear abnormalities. These may include absence, underdevelopment, or abnormal position of auricular structures. Such malformations are often part of craniofacial syndromes affecting the branchial arches, such as Goldenhar syndrome or Treacher Collins syndrome.

Severe ear malformations include anotia and different types of microtia, such as lobular and conchal microtia. The type of deformity depends on which embryonic hillock fails to develop. In most severe cases, malformations of the external ear are associated with abnormalities of the middle ear.

In contrast, ear deformations are more common and differ from true malformations. In ear deformations, the cartilage and skin are normally developed, but the ear has an abnormal shape. These ears can often be partially corrected by gentle digital pressure, indicating normal cartilage elasticity. Ear deformations are thought to result from external mechanical forces or abnormal muscle action rather than from defects in embryonic development. However, Hunter and Weerda classified ear deformations as Grade I dysplasias.

Among the wide range of ear deformations, some forms present as mild yet clearly recognizable changes in the shape of the auricle. One such variant is known as Mozart ear. This ear shape is characterized by a localized prominence or thickening of the crus of the helix, which interrupts the smooth contour of the upper part of the auricle. Despite this visible alteration, the overall structure of the ear remains normally developed, with intact cartilage and skin.

Mozart ear is classified as an auricular deformation rather than a true congenital malformation. It is not attributable to defects in early embryologic development and more likely reflects abnormal cartilage folding or growth in later stages. In most cases the deformity is primarily of aesthetic concern; however, when the conchal convexity narrows the external auditory meatus, functional problems such as cerumen impaction, conductive hearing loss, and difficulty using in-ear devices may occur, as observed in the present case.

Although Mozart ear is commonly referenced as a historical fact, several reports have documented patients presenting with conchal inversion. Normally, the auricle has a concave contour; when it becomes convex, the condition is referred to as an anteverted or inverted auricle.

The Mozart ear was first described by Gerber in 1898 as a combination of narrow slit-like external auditory canal, absent antitragus and square-shaped auricle. This deformity was first described in 1996 by Yi and Walker, who named it an «unusual auricular deformity» [20]. Later, in 2000, Shetty et al. reported a series of similar cases, referring to it as a «reversed or convex auricle» [13]. In 2015, Schönauer et al. introduced the term «anteverted auricle» [10]. Regardless of the terminology used, the defining feature is an unusually convex conchal surface, while the norm suggests a concave shape. For instance, A. Paton estimated the prevalence of this deformity at 1 in 1000, and Jose E. Telich-Tarriba et al. (2017) reported an incidence of only 0.5% [9, 15].

Varying degrees of outer ear deformities are thought to result from alterations in the embryonic development at the ear differentiation stage. Some researchers suggest that this pathology can be caused by external mechanical forces or abnormal development of the auricular muscles [4, 17].

The anteverted auricle belongs to the group of auricular deformities and may be unilateral or bilateral [6, 8, 15, 18, 19]. The deformation may be triggered by abnormal muscular vectors caused by aberrant auricular muscle attachments (e.g. cryptotia) and/or muscle imbalance (e.g. protruding ears), which can arise from abnormal intrauterine or postnatal positioning. The most commonly affected structure is the helix, leading to wrinkled, Stahl's, or protruding ears. Due to their rather solid structure, central auricular components – the concha, root of the helix, and tragus – are generally less susceptible to deforming forces [5].

Many patients remain asymptomatic; however, some develop functional problems. One such problem is the potential development of external auditory meatal stenosis. When the conchal convexity approaches the meatus, it can obstruct the external auditory canal, leading to cerumen impaction and conductive hearing loss. Moreover, for patients using hearing aids or certain headphone types, the convex auricular surface can cause difficulties in fitting and retention. These issues tend to be more pronounced in cases affecting the entire auricle or a large portion of it. For example, our patient experienced similar difficulties in retaining earphones.

The treatment of anteverted auricles depends on the patient's age at presentation. Younger patients are usually managed conservatively with splints or molding devices to reshape the external ear. Auricular deformities respond best to non-surgical treatment during the neonatal period, when auricular cartilage is soft and pliable due to high levels of hyaluronic acid and free estradiol within the first three days after birth. Molding with splints is a safe and effective neonatal treatment option [10, 20]. Non-surgical techniques have included splinting, molding, and digital pressure using various materials – from dental compounds to silicone – secured with adhesive tapes. Schönauer et al. and Olshinka et al. reported excellent results in neonates using non-surgical approaches [7, 11]. However, after the neonatal period, the auricular cartilage becomes more rigid and less malleable; in such cases, the success rate of non-surgical correction drops to approximately 50% [16]. Various surgical techniques, as mentioned above, can be applied in later childhood or adulthood.

Auricular deformities may cause both aesthetic and functional problems. In the neonatal period, splinting is a simple, safe, and predictable corrective method. After this period, when the cartilage is non-malleable and the patient seeks correction, surgery remains as an alternative option and has been known to show positive results. The choice of technique depends on the surgeon's experience. Surgical correction methods here include excision of the conchal cartilage without suturing [11, 18, 19, 20] and reversal of the cartilage as an autologous graft [8, 14, 17].

Hong noted that the amount of cartilage is not excessive yet merely distorted by inversion and described correction through a posterior incision on the convex surface of the concha. Scutt et al. proposed an anterior approach involving a T-shaped incision and cartilage mobilization to the desired shape, followed by fixation with sutures [12].

We believe that although all these techniques yield satisfactory aesthetic outcomes, cartilage-mobilizing methods result in greater improvement of external auditory meatus occlusion. In patients with hearing loss, improving external auditory meatus patency is essential. In our opinion, cartilage-mobilizing procedures, which we describe as «mobilizing conchoplasty» and which are referred to as the «T-shaped incision and mobilization» technique by Scutt et al., are best suited for these patients [12].

There remains ambiguity surrounding the term «Mozart ear,» which lacks a comprehensive definition or description of its treatment. The anomaly, also referred to as «Wildermuth's ear» after the neurologist Hermann A. Wildermuth, who first described it, is associated with Wolfgang Amadeus Mozart and his son Franz. This congenital deformity is characterized by a posteriorly directed helix, resulting in a prominent prehelix and an altered external ear appearance.

Neurologist Hermann A. Wildermuth first described this condition, identifying it in the left auricle of Wolfgang Amadeus Mozart and his son Franz (Figure 6). Clinically, the deformity may be unilateral or bilateral, and it is characterized by cavum conchae convexity and slit-like narrowing of the external auditory canal entrance, often hindering the use of intracanal devices. The mode of inheritance is autosomal dominant. Despite the malformation, Mozart's hearing abilities remained unaffected, and he went on to become one of history's most celebrated composers.

Figure 6. Watercolour from the biography of Mozart by Georg Nikolaus von Nissen, 1828.

According to medical literature, such abnormalities may be associated with congenital syndromes or malformations in other systems, especially the urinary tract [16, 15]. The exact cause of Mozart's death at age 35 remains speculative due to lacking reliable medical records. Although several possible causes of Mozart's death have been proposed, including poisoning, none has been definitively proven. In 2001, Wang et al. explored a possible link between auricular malformations and renal abnormalities [17].

Their review reported a higher prevalence of structural kidney anomalies among individuals with ear deformities compared to the general population. Izzedine et al. (2004) suggested that the relationship between auricular and renal anomalies during embryonic development might be associated with mesodermal induction altering the normal differentiation of both organs.

CONCLUSIONS

Mozart ear remains a rare deformity, even in specialized ENT centres. Anteverted conchae may be underdiagnosed. Inversion of the cavum conchae results in a convex contour, primarily causing aesthetic concerns, which is why patient and family preferences should be carefully considered. Correction is typically straightforward and may not necessitate surgery if it is diagnosed early. Surgical intervention focuses on correcting the convex auricle, but the chosen technique must be tailored to the case severity and the individual patient's needs.

Prospects for Further Research. Further studies should focus on collecting larger case series of patients with Mozart ear to better characterize anatomical variability and associated anomalies. Systematic documentation of clinical findings, supported by standardized photographic and morphometric analysis, would allow more accurate classification of this rare deformity. Comparative evaluation of different surgical techniques and their modifications may contribute to the development of standardized treatment algorithms. Long-term follow-up studies are needed to assess the stability of aesthetic outcomes and patient satisfaction.

COMPLIANCE WITH ETHICAL REQUIREMENTS

The research was conducted in compliance with the basic provisions of bioethics, the Council of Europe Convention on Human Rights and Biomedicine (April 4 1997), the Declaration of Helsinki of the World Medical Association on Ethical Principles for Medical Research Involving Human Subjects (1964-2008), as well as Order No. 690 of the Ministry of Health of Ukraine dated September 23, 2009. Consent for the use of data and publication of the article was obtained from the patient.

Study Limitations. The rarity of Mozart ear limits the number of clinical cases and reduces the possibilities for statistical analysis. Anatomical variability of the

deformity and differences in surgical approaches complicate comparison of outcomes and assessment of long-term results.

Primary Data. This study describes one clinical case of a congenital external ear deformity known as Mozart ear. The primary data included clinical examination, photographs taken before and after surgery, preoperative planning materials, and the surgical results with evaluation of the aesthetic outcome.

Declaration of the use of generative AI in manuscript preparation. During the preparation of this manuscript, the author used ChatGPT (GPT-5, OpenAI; accessed 5 September 2025) to assist with language editing (grammar and style) in the Discussion and References sections. The tool was not used to generate content, ideas, data, or conclusions. The author reviewed and edited all output and takes full responsibility for the accuracy, originality, and integrity of the publication.

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The author declares no conflict of interest.

AUTHOR CONTRIBUTIONS

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The author contributed to all aspects of the study and manuscript preparation.

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Резюме

ВУХО МОЦАРТА: РІДКІСНА ДЕФОРМАЦІЯ ВУШНОЇ РАКОВИНИ

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Вступ. Вроджені аномалії вушної раковини спостерігаються приблизно у 30% новонароджених та є найчастішими краніофаціальними вадами із загальною поширеністю 1 на 6000 живонароджених; 15-20% деформацій зникають спонтанно. При ранній діагностиці більшість з них можна коригувати консервативно за допомогою шинування; після неонатального періоду зазвичай потрібне хірургічне втручання. Вухо Моцарта – рідкісна деформація, для якої характерна інверсія *cavum conchae* зі щілиноподібним звуженням зовнішнього слухового проходу.

Мета. Представити рідкісний випадок хірургічного лікування вуха Моцарта та описати модифіковану техніку, інтраопераційні особливості й найближчі клінічні результати.

Матеріали та методи. Пацієнт, 23 роки, звернувся з однобічною інверсією правої вушної раковини та щілиноподібним стенозом зовнішнього слухового проходу, виявленим у ранньому дитинстві, а також зі скупченням сірки та неможливістю утримувати внутрішньовушні навушники. Під загальною анестезією виконано корекцію *cavum conchae*: резекцію та реверсію хряща раковини, його реімплантацію як вільного трансплантата й розширення слухового проходу швами Mustardé. Післяопераційний період без ускладнень.

Результати. Покращення контуру раковини спостерігалося вже протягом першого післяопераційного тижня, оптимальна увігнута форма з розширеним отвором слухового проходу – через один місяць. За 6 місяців спостереження корекція збережена, задня симетрія відновлена, повернено можливість комфортного користування навушниками, пацієнт задоволений результатом.

Висновки. Вухо Моцарта – рідкісна деформація, що спричиняє переважно естетичні та, іноді, функціональні проблеми. Рання діагностика дозволяє провести нехірургічну корекцію; після неонатального періоду методом вибору залишається хірургія. Обсяг втручання слід адаптувати до тяжкості деформації та побажань пацієнта.

Ключові слова: **аномалія вуха, деформація раковин, увігнуті раковини, хірургічна корекція**

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