Conclusions: Pain presenting in a delayed fashion after CI, in the absence for other causes of pain, may represent indolent infection and can be successfully treated with explantation/antibiotics and reimplantation.

Methods: Delayed CI infection was diagnosed on the basis of clinical symptoms and positive operative cultures. Presenting symptoms, medical and surgical treatment regimens, and audiological outcomes were reviewed retrospectively.

Results: In 578 patients (868 implants), 9 patients (8 females) were diagnosed with delayed CI infection. All presented with complaints of pain, typically localized to the area over the receiver stimulator and were unrelated to other causes of pain such as trauma, external/internal device failure, skin breakdown or neuralgia.

Mean age of CI was 81 months (range 13-180 months). Average time between initial CI and explantation was 106 months (range 8-174 months) and between explantation to CI reimplantation was 5.5 months (range 3-8 months).

Etiologies of hearing loss included Waardenburg syndrome (n=2), enlarged vestibular aqueduct (n=2), Cogan's syndrome (n=1), and unknown (n=5). A variety of devices and manufactures were identified.

The most common causative agent for infection was Propionibacterium acnes and Staph non aureus.

All patients were treated with a prolonged course of oral and/or IV antibiotics; with continued pain tissue cultures and subsequent explantation was performed.

For most patients, post –CI reimplantation speech perception performance returned to preoperative levels.

The incidence of infectious complications has been reported to between 1.8 to 8.2%. The majority of post operative infections respond to oral/IV antibiotics and wound care.

Delayed infections (many years after surgery) may be more resistant to IV antibiotic treatment alone due to the presence of biofilms on the CI.