External ear anomalies in children or microtia occur once in about every 7,000 to 8,000 births in the general population. And it is fairly common for microtia to be associated with other congenital abnormalities. Among associated malformations, facial cleft and cardiac defects are the most common followed by anophthalmia or microphthalmia, limb reduction defects, renal malformation, and holoprosencephaly. Congenital aural atresia is a birth defect characterized by hypoplasia of the external auditory canal and often associated with microtia or dysmorphic features of the auricle and middle ear with occasional abnormalities of inner ear structures. Parents of newborn with microtia and congenital aural atresia often develop great anxiety. Therefore it is important for clinician to provide proper counseling and realistic plan of management. Initial management of microtia and congenital aural atresia should be directed towards determining the auditory function rather than cosmesis of the abnormal pinna. In unilateral cases, if the hearing in the contralateral ear is normal, these children usually develop normal speech and normal intellectual growth without any surgical intervention. For bilateral cases, the audiologist should manage these children from the beginning. Amplification by bone conduction hearing aid should start as early as possible. It is important to be selective in consideration for microtia surgery and canal reconstruction. High resolution CT scan of the temporal bone is important in patient selection for surgery. We limit canal reconstruction to ears with normal cochlear function and normal or near-normal pneumatization of the tympanic cavity. Good hearing results can be achieved by removing most or all of the bony atresia. The effectiveness of skin grafting after the bony canal has been drilled is the most important factor in the success of canal reconstruction. Facial asymmetry due to abnormal facial and temporal bone growth is a relative contraindication for canal reconstruction. There is a higher risk of facial nerve injury and poor hearing outcome. Pinna reconstruction may be performed without canal reconstruction in these cases. At the Department of Otorhinolaryngology, Universiti Kebangsaan Malaysia Medical Centre, canal and pinna reconstruction is usually performed after the age of 10 years except for cases of canal cholesteatoma when surgery is performed earlier. Management of congenital microtia and canal atresia needs full evaluation by ORL surgeon, audiologist, paediatrician and may be psychologist for proper counseling of realistic plan and optimize the functional outcome.