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Voice rest after vocal cord surgery: current practice

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Introduction: Vocal cord (VC) pathologies are commonly seen in ENT. Voice rest is commonly recommended after VC surgery with the aim of improving post-operative healing and voice quality. However there are few clinical studies on which to base practice and no standard protocol.

Objective: Establish common practice regarding voice rest post-VC surgery.

Method: A survey was circulated via email invitation to 361 ENT surgeons on the Expert Panel of ENT UK, between October and November 2011. SPSS and R software packages were used for statistical analysis.

Results: 86.5% of respondents agreed that complete voice rest means absolutely no sound production but there was variability in the definition of relative voice rest which is commonly advised after surgery for benign lesions (46.3%) and granulomas (40.9%). 52.5% of respondents did not recommend any voice rest after surgery for malignant vocal cord lesions. For laryngeal papillomatosis and intermediate pathologies there was no consensus regarding type of voice rest. For all pathologies except malignant lesions, there was no consensus on length of voice rest (range 1-14 days). Less experienced surgeons were more likely to recommend fewer days of voice rest after surgery for all pathologies except intermediate lesions.

Conclusion: The survey demonstrated a lack of consistency in advice given to patients after vocal cord surgery. The variation in practice amongst ENT surgeons may arise from an absence of robust evidence. Thus, there is need for more research into the effects of voice rest after vocal cord surgery in order to establish evidence-based standards of care for these patients and optimise post-operative voice quality, without subjecting patients to unnecessary lengths of voice rest.

Optimum timing of postoperative radioiodine remnant ablation (RRA) in differentiated thyroid carcinoma (DTC) - the Kent and Medway Cancer Network experience

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Introduction: Radioiodine Remnant Ablation (RRA) involves destruction of residual thyroid tissue in the thyroid bed following total thyroidectomy in patients with differentiated thyroid carcinoma (DTC). There is currently no specific guidance from the British Thyroid Association (BTA) and American Thyroid Association regarding RRA timing post-operatively.

Therefore, a consensus was reached in Kent & Medway network thyroid disease orientated group that a standard of 12 weeks should be set for administration of RRA following surgery.

Objective: To look at existing guidelines/evidence for the optimal timing of postoperative RRA in DTC patients and to compare our current practice against this.

Method: DTC patients receiving postoperative RRA across 3 NHS Trusts (East and West Kent) during Jan 2008-Dec 2009 were included in the study.

Results:
82 patients were included in the study (female:male 3.3:1, age range 17-88years, mean 53 years. Histopathology: Papillary (38%), follicular (29%), papillary with follicular variant (20%), Hurthle cell (10%). Operations: Hemithyroidectomy/ Completion Thyroidectomy (46%) (38/82), Total Thyroidectomy (33%) (27/82), Hemithyroidectomy/ Completion Thyroidectomy/Level VI Dissection (9%) (7/82), Total Thyroidectomy/Level VI Dissection (7%) (6/82). Timing: Range 3-278 days (mean 66 days), overall 68% meeting 12-week-standard (Trust A 92%, Trust B 88%, Trust C 45%). The significant delay in Trust C was caused by therapy room refurbishment during the study period.

Conclusion: Although there are currently no official guidelines a target of 12 weeks for administration of RRA following surgery is attainable and may form the basis of patient outcome studies in the future. Significant delay in RRA in DTC patients may have a negative impact on physical outcomes or patient satisfaction.

The financial cost of readmission for post tonsillectomy bleeds

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Objective: To assess the impact of the Governments new policy of not paying for readmissions within 30 days of elective surgery. Specifically looking at Post Tonsillectomy bleeds in a District General Hospital.

Method: This study was carried out at Gloucestershire Royal Hospital. This was a prospective study between February 2011 and February 2012. All surgeons undertaking tonsillectomy were asked to complete an audit pro-forma. The hospital Informatics Department were approached to provide information with regards to secondary readmission rates. The hospitals readmissions officer was approached to work out the exact amount of financial loss due to readmissions post tonsillectomy.

Results: In total 460 patients underwent tonsillectomy. There were 58 readmissions in total for postoperative bleeding. 53 were treated conservatively while 5 returned to theatre. This represents a loss of £33,000 to our ENT department under new government policy

Conclusion: This study demonstrates the impact of new government policy on a DGH ENT Department. The national tonsillectomy audit provides ample evidence demonstrating the degree of post tonsillectomy bleed that should be considered as acceptable. This evidence should be presented to the Department of Health in order to provide an acceptable level of post tonsillectomy bleed that is not financially penalised.

The 'Scratch test' proves to be a reliable test post-tympanomastoid surgery

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Objective: To identify whether the 'Scratch test' can be used an alternative to the Weber's test following tympanomastoid surgery.

Methods: This single-centre prospective study assessed major tympanomastoid surgery patients over a six month period. Patients were assessed post-operatively on day 0 or day 1 of surgery using a standardised pro-forma. A Weber's test was performed using a 512Hz tuning fork, placed mid line on the forehead to assess the direction of sound localisation. This was directly compared with a 'Scratch test', by asking the patient the following whilst scratching the head bandage over each ear: 'Can you hear this? And which side is loudest?'

Results: 31 patients were assessed in total. Tympanoplasties, mastoid operations, myringoplasties and other procedures were included, all of which had standard external auditory canal packing and head bandage. Assessment with Weber's test found 25 [80.6%] patients to have sound lateralising to the operated ear. In comparison 27 [87.1%] patients lateralised sound to the operated ear with the 'Scratch test'. Overall, Weber's test had a sensitivity of 83.3% and specificity of 96.8% compared with a sensitivity of 90% and specificity of 96.8% for the 'Scratch test'. No patients had a dead ear following surgery.

Conclusion: The Scratch Test proved to be more accurate than traditional post-operative tuning fork assessment and provides a quick, accurate and simple solution for when such equipment is unavailable.

ENT Training and the Independent sector

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Objective: To ascertain the level of ENT training taking place in Independent sector treatment centres (ISTC) across the UK

Method: All 29 ISTCs were contacted for a telephone interview with their general managers. A telephone interview was carried out. All 29 ISTCs were successfully contacted.

Results: 24 out of 29 ISTC's carried out elective ENT procedures which ranged from tonsillectomy, adenoidectomy, septoplasty, myringoplasty, grommets and functional

endoscopic sinus surgery. Out of the 24 ISTC's none of them had any surgical ENT trainees present

Conclusion: The role of the Independent sector in providing NHS funded ENT treatment is increasing. The training opportunities available within the independent sector have not been utilised with no trainees present at ISTCs. Training provision needs to be a consideration when commissioning private providers for NHS funded work.

Stemming the Flow: Audit of Epistaxis Management in Middlesborough

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Introduction: Epistaxis is the most common ENT emergency. In 2010, mean inpatient duration was 1.9 days. Following EWTD, doctors increasingly cross-cover ENT, often with limited training in epistaxis management.

Objective: To audit the management of epistaxis in accordance with South Tees Trust Adult Epistaxis Management Protocol over a 3 month period.

Method: Data was collected prospectively from patients referred to ENT with epistaxis aged over 16 between December 2011 and March 2012. Post-operative patients were excluded.

Results: 79 acute epistaxis referrals were audited. 36 patients were admitted and 43 were managed as outpatients. Average age was 70 (range 19-92). 39 patients had hypertension and 49 (62%) were anticoagulated (29% warfarin, 23% aspirin, 10% clopidogrel). 39/43 outpatients were treated with $AgNO_3$ cautery (which was only performed by ENT doctors) and 6 patients were discharged without Naseptin. 5/43 patients were subsequently admitted less than 2 weeks after initial treatment. Average inpatient duration was 3 days (range 1-11). 3 patients who required two consecutive nasal packs did not undergo SPA ligation as recommended by our protocol. Of the 5 patients requiring Foley catheters to control posterior epistaxis, only 2 underwent SPA ligation. 5 inpatients were subsequently re-admitted and 2 of these required SPA ligation.

Conclusion: Our current inpatient duration is longer than the national average. This may be a result of bias towards repeated or prolonged packing over operative intervention. This audit highlights the need for greater consideration of SPA ligation in appropriate patients. Also, further training in cautery is necessary to reduce nasal packing by non-ENT doctors and subsequent admission. After appropriate dissemination of audit results, we intend to re-audit and demonstrate reduced admissions and inpatient duration.

Effective management of acute ENT referrals

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Introduction: In our department foundation(F2) doctors on a 4 month ENT rotation, with little or no prior ENT experience, are assessing and treating a large number of patients as ward attenders. Their lack of specialist experience and competency, coupled with limited senior support on the ward, may result in an inability to make effective management decisions. This is reflected in the high number of ward re-attenders. Hence we look for ways to provide a more efficient service which aims to improve patient care and safety, whilst providing junior doctor training, in a well-supported environment.

Objectives: Identify patients currently seen as ward attenders who could be more appropriately managed in an alternative setting eg emergency clinic, Consultant clinic, nurse led microsuction clinic, A+E or in the community.

Method: First cycle: retrospective audit of ward attendees over a one month period. Second cycle: establish additional emergency clinics (5 patients only), run by the F2 doctors with senior support, and re-audit numbers of ward attenders.

Results: 74 ward attenders were seen by junior doctors in one month. Approximately half were re-attenders, or patients more appropriately assessed in an emergency clinic for semi-acute referrals, running alongside a senior providing the necessary advice. Preliminary results of the second cycle, following implementation of two additional emergency clinics, demonstrated a significant reduction in ward attenders, suggesting more effective management and discharge of patients.

Conclusion: Many ENT departments are faced with the dilemma of providing an emergency service when staffed by junior doctors working limited hours, for less than 6 months. Implementation of the F2-run emergency clinic with immediate senior support, resulted in a reduction of ward attenders, and provided an invaluable teaching opportunity in which supported junior doctors rapidly gained experience and confidence, thus improving patient management.

Clinical coding accuracy audit in otolaryngology – closing the audit loop

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Introduction: Clinical coding is an increasingly important issue for service providers within NHS. It has managerial and clinical significance as well as financial importance particularly with the advent of payment per result system (PBR).

Objective: To estimate the accuracy of the clinical coding for the procedures we perform in our ENT department

Method: A clinical audit was performed to monitor our coding accuracy in our inpatient department as well as theatres.

Results: There was a satisfactory degree of accuracy for the performed surgeries which was affiliated to the fact that surgeons were instructed to write down the code for every surgery and coding sheets were supplied in the theatres as a recommendation of a previous audit. The emergency inpatient admission coding, by contrast, was greatly inaccurate (only 7 correct codes out of 23). The reason thought to be that many procedures during admissions were missed because they had not been documented or were unclear which made it hard for the coders to find out. As a result we have designed a form with the most common procedures. All admitting doctors were instructed to tick every procedure which is carried out during admission period. Another audit was performed which showed significant improvement in the coding accuracy(2 coding errors in 17 admissions)

Conclusion: We concluded that coding accuracy is essential for financial and clinical purposes. The coding sheet we introduced in our department is a very valuable tool which helps clinician as well as coders to code our services accurately.

Comparative study of the realism and usefulness of two virtual temporal bone simulators: The VOXEL-MAN TempoSurg and The Visible Ear Simulator

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Background: The use of virtual temporal bone simulators may be beneficial in the training of ENT surgeons. There are several such systems available but no previous studies have been undertaken to compare them. The cost of these systems has been a barrier to wider uptake (VOXEL-MAN TempoSurg £40,000), but the Visible Ear Simulator (VES) is considerably cheaper to set up (£3,000).

Objective: To compare the aforementioned simulators in terms of realism and usefulness.

Method: ENT higher surgical trainees in the South West of England were recruited to the study. Each trainee was allowed ten minutes on each of the simulators. They then completed a questionnaire recording demographic data and rating their perception of realism and usefulness in multiple domains using a 5-point Likert scale.

Results: 10 trainees participated in the study ranging from ST3 to ST7. All had prior experience of temporal bone drilling. Considering the means of the ratings, the simulators were grossly comparable (e.g. overall realism 2.9 v 3.0, usefulness for teaching anatomy 3.8 v 4.0, usefulness in teaching surgery 3.2 v 3.3, usefulness in teaching drilling technique 3.1 v 3.0).

Conclusion: Temporal bone simulators may be a useful adjunctive tool in ENT training. The Visible Ear Simulator presents an affordable alternative to the TempoSurg system. Validation studies for the VES are in progress and an approach to curriculum integration will be investigated.

Can the lymphocyte count alone predict Epstein Barr related infectious mononucleosis, eradicating the need for monospot testing?

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Objective: To evaluate the predictive use of the lymphocyte count in the diagnosis of Epstein Barr Virus (EBV) related Infectious Mononucleosis (IM) cases, eradicating the need to carry out monospot tests on all patients admitted with sore throat, fever and lymphadenopathy.

Method: Single centre retrospective review of 726 consecutive patients undergoing monospot testing at the University Hospital Southampton (UHS) between 1st October 2011 and 20th January 2012. Blood results of patients undergoing monospot testing were compared to full blood count results examining; lymphocyte, monocyte, neutrophil and total white cell counts examining for predictive correlations.

Results: When the lymphocyte count was ≤4 10*9/L 99.1% of patients studied had an associated negative monospot result (sensitivity of 84% and specificity of 94.5%).

Conclusion: Of all the white cell indices measured the lymphocyte count was the most predictive of a negative monospot result. Following this study monospot testing can now be limited to patients with a lymphocyte count >4 10*9/L. Within UHS alone this would result in the saving of 1938 tests annually (£2500 as each monospot test costs £1.29) resulting in a significant impact on cost if multiplied across the UK and beyond.

Anti-platelet Drugs in Elective ENT Surgery

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Objective: To ascertain current preoperative management of patients on anti-platelet drugs undergoing elective ENT surgery in the UK.

Methods: An online survey was distributed to the Expert Panel of ENT-UK, the British Association of

Otolaryngologists Head and Neck Surgeons between 13th January 2011 and 15th February 2011.

Results: 303 members were contacted and the response rate was 55% (167 replies), 78% of whom were Consultants. 91% asked their patients to stop anti-platelet drugs prior to an elective procedure. 9% did not stop Clopidogrel or Aspirin. Nasal and Head & Neck surgery was the commonest reason for stopping medication, with endoscopy being the least common. 20% were unsure what bridging therapy was. 9% had reported some kind of adverse effect of stopping anti-platelet drugs such as CVA/TIA. The commonest consequence of continuing medication was haematoma. 72% would recommence medication within 3 days after surgery while 23% would restart it immediately. 45% of departments had no protocols in place but 86% would welcome a protocol.

Conclusion: There is very little literature on anti-platelet medications and ENT surgery. Abrupt cessation of anti-platelet drugs in patients with coronary artery disease can have serious rebound effects. An increasing number of patients have an indication for anti-platelets and thus their management is crucial. Most consultants have welcomed a protocol for anti-platelet management. The outcomes of this paper have allowed patients to be classified into high and low risk categories. Appropriate recommendations for the pre operative anticoagulation for each group have been suggested.

An audit of assessment of voice in thyroidectomy patients

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Background: Recurrent laryngeal nerve damage is a potentially devastating complication of thyroidectomy and can mean the end of career for the professional voice user. Thyroidectomy is performed by both ENT and general surgeons. The British Association of Endocrine and Thyroid Surgeons (BAETS) recommend pre-operative laryngoscopy in thyroidectomy patients. We present a closed-loop audit of pre-operative fibreoptic vocal cord checks to determine whether implementation of a rapid-access otolaryngology voice assessment service improves the rate of pre-operative vocal cord checks.

Method: Data were collected retrospectively from thyroidectomies performed within the Brighton and Sussex University Hospitals Trust over a one year period (Period 1 – P1). Data were analysed, a rapid-access otolaryngology voice assessment service instigated, data disseminated to both ENT and general surgery departments, and a prospective re-audit performed over a 6 month period (Period 2 – P2).

Results: 89 patient notes were assessed in P1, and 26 over P2. Pre-operative vocal cord check rate increased from 87.6% (78/89) to 92.3% (24/26). Post-operative documentation of voice increased from 68.5% (61/89) to 96.1% (25/26). The rate of patients with post-operative dysphonia being given an ENT/Voice clinic appointment improved from 50% (9/18) to 100% (2/2).

Conclusion: The otolaryngology voice assessment service improved the trust pre-operative assessment of vocal cords by facilitating easy access to flexible nasoendoscopy, especially for the general surgeons. Dissemination of the original audit data and education of the departments about current guidelines improved documentation of post-operative assessment of voice. Management of dysphonia post-op improved dramatically with easier access to ENT/Voice clinics.

Pro-forma based documentation in Head and Neck MDT

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Objectives: To compare local services of Head and Neck Cancer Management against national expectations set by DAHNO [Data for Head and Neck Oncology]. To compare local performance pre- and post-implementation of a standardised MDT pro-forma.

Method: This retrospective re-audit gathered data from the records collected at departmental MDT meetings. Standards were taken from the clinical lines of enquiry that are published annually to identify key aspects that reflect the quality of local head and neck cancer services.Initial audit inclusion criteria consisted of all new head and neck cancer diagnoses for the year 2010 [pre-implementation], findings were presented and implementations suggested. Data was then extended to include all new head and neck cancer diagnoses for the year 2011 [post-implementation] as a comparative study.

Results: 208 cases were identified in total, 95 cases in 2011 and 113 cases in 2010. 94 [99%] and 99 [88%] cases were discussed at MDT respectively. The reporting of TNM staging improved with 77 [82%] cases identified for the year 2011 compared with 71 [62%] cases for the preceding year, now above national standards of 79%. Of those undergoing treatment in 2011, 62 patients [65%] were seen by a clinical nurse specialist [CNS] prior to commencement and 38 patients [40%] underwent pre-treatment dietetic assessment.

In comparison, only 50 patients [54%] were seen by a CNS and not a single dietetic assessment was completed in 2010.

Conclusion: Previous shortfalls have been vastly improved with the instalment of an MDT pro-forma, it is therefore proposed that a standardised pro-forma should be employed nationally.

The Prevalence of Surfer's Ear in Cornish Surfers

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Objective: To establish a prevalence of external auditory canal exostoses in an active Cornish surfing community.

Method: During a period of two weeks in autumn 2010 105 surfers, 91 male and 14 female (average age 30.08 years, SD 11.2, range 9-64 years) were interviewed and otologically assessed on a series of highly frequented Cornish surfing beaches. The degree of exostoses was graded into mild (<30% obstruction), moderate (30-60% obstruction) and severe (>60% obstruction). For each individual an absolute cold water exposure value was calculated in hours. These values were grouped and correlated with the otological findings.

Results: Exostoses were found in 63.81% (134 ears) of the participants, 33.33% were mild, 18.1% moderate and 12.38% severe. The degree of exostoses showed a significant correlation with the years spent participating in the sport ($n=210$; $p<0.001$) and the absolute cold water exposure in hours ($n=105$; $p<0.004$). There were also a significant number of surfers whose degree of exostosis did not show the expected correlation with the number of hours spent in the water; there was a cohort ($n=37$) who had many hours of water exposure with minimal exostosis and a further number ($n=9$) who had spent relatively little time in the water but had a significant degree of exostosis.

Conclusion: Exostoses of the external auditory canal are common in Cornish surfers. The prevalence established in this study matches previously published data from different parts of the world with similar sea water temperatures. There appears to be a spectrum of susceptibility however in that there are a group of surfers whose extent of water exposure does not show the expected severity of exostosis.

