What is in this issue

Bumper ‘Our experience’ issue

This issue has an unusual composition in having a different balance of types of contribution. This is due to several factors, the most important one being that Clinical Otolaryngology has a policy of publishing articles as soon as practical after their being accepted. Our experience contributions are now by far the commonest type of submission, and a higher proportion of these are accepted [usually after several revisions] than other types. Clinical Otolaryngology’s policy has therefore been to have these available on their website as soon after acceptance as practicable. However, with a backlog of 14 contributions, the opportunity has been taken to catch up with these in the printed version.

Many of our subscribers are likely to welcome this different balance of contents as the correspondence section is what they most often eventually get round to reading.

Harmful medication used in ORL

With time, and larger numbers of patients have been treated with medications of proven benefit, their adverse effects are increasingly being recognised. This issue contains two important Editorials, based on two recent, high-quality papers in other journals, which will materially affect ORL clinical practice.

Codeine fatalities following tonsillectomy have lead to a ban on their use

In Europe since February 2013, the prescription of codeine to children following tonsillectomy has been contraindicated. This decision mirrored a similar earlier decision in the USA and is based on a report in Paediatrics of the death of 10 boys following its use for post-tonsillectomy pain relief. Whether this is an overreaction to what must overall be a very small death rate, considering over 500 000 tonsillectomies are performed each year in the USA, is covered by Peter Robb’s Editorial on page 365. On the practical side, this editorial also addresses what medication should be used to replace codeine in paediatric practice.

Corticosteroids increase the risk of thrombo-embolism

The abstract of a Danish population paper published in JAMA Int Med is reproduced on page 379, followed by an Editorial commentary by Neil Bateman [pg 380]. The take-home message here is that both oral and inhaled steroids increase the risk of venous thrombo-embolism up to twofold. This risk is highest for ‘new’ prescriptions and is dose dependant. So although the risk of thrombo-embolism is low, for example, in patients being prescribed nasal steroids for chronic rhinosinusitis, the risk though doubled still remains low. Whether patients should be informed of this ‘doubling’ of risk needs discussed.

Head and neck surgical research in the UK: more trials but a few tribulations

Historically surgeons have been reticent about having their surgery subjected to scientific evaluation by the rigours of randomised controlled trials. This is mainly because they do not have equipoise regarding the possibility of their operation being of little, or even no, benefit to the patient. This lack of equipoise is perhaps understandable as all forms of surgery have a considerable placebo effect. In the absence of randomised controlled trials, what happens is that operations whose benefits are mainly attributable to a placebo effect [such as endolymphatic sac surgery] are with time replaced by other operations that have a much clearer effect [such as chemical labyrinthine ablation]. The problem with this evolutionary process is that the transition time of change in practice will be considerably longer than if there had been a randomised controlled trial.

Head and neck cancer is a condition that if untreated usually results in death with a terminal period where the quality of life is poor. So the question here is which regime of treatment gives the greatest chance of survival with the best quality of life. Each of the alternative regimes will have their advocates promoting their own specialty options. Management of patients with head and neck cancer in the UK is now by multidisciplinary team that as well as having surgery as an option has radiotherapy and chemotherapy as alternatives. In this situation, equipoise frequently exists and makes multicentre trials eminently practical. Increasingly, there is a will to make the most of this opportunity and those leading this renaissance are to be congratulated. Their task is still not an easy one, but funds appear to be there to perform trials, and the ORL profession should be proud and continue to advocate such trials.

The Editor