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Diagnostic criteria and core outcome set development for necrotising otitis externa, symptomatic evaluation in patients awaiting septoplasty and early versus late tracheostomy in critically ill patients

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Editorial

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A *tour de force* article in this month's issue describes the development of standardised diagnostic criteria and a core outcome set for necrotising otitis externa, achieved using international best practice guidelines and incorporating patient and multidisciplinary stakeholder engagement.[1] Adoption of these diagnostic criteria and the core outcome set should facilitate the optimisation of future necrotising otitis externa research through consistency in reporting and enhanced data synthesis, thereby enabling best practice to be identified.

Nasal septoplasty is one of the most performed procedures within ENT. In a study by Williams *et al.* in this month's issue, patients on the waiting list for septoplasty and/or inferior turbinate reduction surgery were reviewed using a validated patient-reported outcome measure tool, the Nasal Obstruction Symptom Evaluation instrument, to assess symptom severity.[2] A pre-defined threshold of 30 or more on the Nasal Obstruction Symptom Evaluation scale was taken to warrant nasal surgery in patients with nasal airway obstruction secondary to a deviated nasal septum, based on the recently published Nasal Airways Obstruction Study trial.[3] The authors found that the Nasal Obstruction Symptom Evaluation questionnaire is a quick and simple way to evaluate, triage and prioritise patients on septoplasty waiting lists, helping to identify patients still requiring surgery.

Other notable articles in this month's issue deserve special mention. The treatment of the clinically node-negative contralateral neck in patients with human papillomavirus (HPV)-positive oropharyngeal squamous cell carcinoma remains controversial. An article in this month's issue analyses of the rate of contralateral nodal metastasis in HPV-associated oropharyngeal squamous cell carcinoma, thereby helping to clarify which patient cohorts would benefit from bilateral neck treatment.[4] The contralateral nodal disease rate was 12.7 per cent, of which 2 per cent were occult findings. The most commonly involved contralateral nodal station was level II. The presence of extranodal extension and multiple ipsilateral positive nodes was associated with an increased risk of contralateral nodal disease.

Finally, a manuscript in this month's issue adds to the growing body of literature examining the benefits of early versus late tracheostomy in critically ill patients, demonstrating an association of early tracheostomy with both shorter intensive care unit length of stay and lower mortality.[5]

References

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