

Editorial

Cite this article: Fisher EW, Fishman J. Preparing juniors for on-call ENT, handicap in vestibular schwannoma, nasal packs in epistaxis and sleep apnoea in young children. *J Laryngol Otol* 2024;**138**:591. <https://doi.org/10.1017/S0022215124000793>

Received: 25 April 2024

Accepted: 25 April 2024

The variability in duration, composition (and even existence) of ENT attachments in different undergraduate medical courses and the implications for postgraduate training has been a regular *Journal of Laryngology & Otology* theme in recent decades.^{1–3} An assumption was once made that a new ENT foundation or core trainee (intern equivalent) had a sound knowledge of relevant basic science, basic ENT clinical skills and knowledge of common ENT emergencies. This is no longer a reasonable assumption. This issue has an interesting if predictable qualitative study from Cardiff (UK) in which the investigators interview new ENT juniors in a structured fashion.⁴ The investigators explore learning needs and ideas on solutions to overcome the perceived problems of new ENT juniors in carrying out their duties in the specialty. A general sense of a lack of preparedness is clear. It is helpful for educational supervisors and course planners to know that the ever popular labour-intensive, practically based, peer-led, simulation-assisted and effective ‘boot camp’ approach to induction is well supported by this study and has been the topic of previous favourable *Journal of Laryngology & Otology* articles.^{5,6}

This issue’s paper of the month is from Brighton, Salford and Cambridge (UK) where the researchers looked at groups of vestibular-schwannoma (acoustic-neuroma) patients from Salford and Cambridge who were being monitored over time for their tumours.⁷ They evaluated the patients’ handicaps using a validated quality of life measure (audiovestibular handicap questionnaire) sequentially over time. This paper, which is the first that has examined such a group in this fashion, rather than the usual pre- and post-treatment evaluations, discovers that although the prevalence of some handicap is high, this does not change much over the time that the patient is being observed. These data will assist researchers and clinicians who need to give their patients evidence-based counselling when discussing treatment options and conservative measures.

Nasal packing in epistaxis is still used regularly for many, often pragmatic reasons. *The Journal of Laryngology & Otology* published a systematic review on packing and a trainee-collaborative study on the management of nosebleeds back in 2016–17.^{8,9} Two common non-dissolvable packs (Merocel and Rapid Rhino) were compared in a study^{9,10} from Leicester (UK) in this issue of *The Journal of Laryngology & Otology*. The findings are that both had similar results in epistaxis control and comfort when the packs were in situ, but the Merocel packs were more uncomfortable on removal and the Rapid Rhino packs were more ‘embarrassing’ (presumably due to the visible balloon inflating tubes). These findings were predictable for anyone experienced in using Merocel and Rapid Rhino, but will nonetheless serve to help patient consent and perhaps choice of pack (which has significant cost as well as comfort implications).

Adenotonsillectomy may be the mainstay of treatment for obstructive sleep apnoea (OSA) in children, but there are cases that do not respond favourably to this treatment which turn out to have other airway anomalies. This issue has a study from Thessaloniki (Greece) in which children are examined with rigid laryngotracheobronchoscopy as part of their management (intra-operatively during adenotonsillectomy).¹¹ The authors found that 77 per cent of children had an additional airway anomaly in the under-three-years age group (just 13 per cent if over three years of age) and leads the authors to recommend rigid endoscopy for OSA cases in this age group. This would have implications for tertiary paediatric ENT service provision. Relevant skills and capacity would need to be sufficient in meeting the needs of the numbers of children that could fall into this group. The population studied here was small and the study was retrospective. The authors acknowledge that the evidence from this study needs supplementing, but the findings are impressive and will be important if shown to be widely valid. Previous studies from elsewhere are referenced and support their conclusions. This is food for thought for anyone planning tertiary paediatric ENT care.

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