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EDITORIAL

Glue ear in adults, paediatric sleep apnoea and the nose in exercise

The puzzling condition of otitis media with effusion (OME) in adults is reviewed in this issue by Mills and Hathorn.[1] This complements nicely recent articles by Wasson and Yung[2] on the evidence-based management of otitis media (in its various forms) and the study from Dundee of sinonasal symptoms in patients with ear disease[3] which confirmed the association between the two groups of conditions. The pathology of OME in children is far from clear, and as Mills and Hathorn point out, the situation in adults is no better, with many important gaps in our knowledge.

The more controversial subject of direct treatment of the eustachian tube with balloon dilatation is reviewed by Jufas and Patel, and appropriate caveats are applied in this tricky subject.[4] Mitchell-Innes and colleagues have recently addressed the topic of otic barotrauma.[5]

Nasal physiology has featured strongly in *The Journal of Laryngology & Otology* in the past, and Walker and colleagues' review of nasal function in exercise adds to this legacy admirably.[6] The main points are not controversial in that area, but the recent paper by Ozturk *et al*. dispels the myth that dorsal nasal skin cooling has a physiological basis in the management of epistaxis, as nasal volume (determined by acoustic rhinometry) did not change after cold compresses were placed over the nasal dorsum.[7]

The topic of paediatric sleep apnoea continues to generate interest. The paper by Sharma *et al*.[8] on trends in assessment and management fits in well with recent papers by Lightbody *et al*.[9] on pre-operative overnight oximetry as a predictor of high dependency unit requirements and the multicentre study of the T14 outcome measure in paediatric patients by Hopkins *et al*.[10]

One predictable but disheartening finding by Vijendren *et al*. is that ENT surgeons have perhaps more than their fair share of musculoskeletal problems.[11] This has implications for us all, and for the designers of equipment and operating theatre and clinic layouts, as the ergonomics of most ENT clinics leave a great deal to be desired.

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