Highlights from the Current Issue: September 2019

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Welcome to September! In a few short days, we will all be convening in the vibrant city of New Orleans to celebrate our Annual Meeting & OTO Experience. The meeting offers the otolaryngology community the opportunity to learn the latest science, network with colleagues from around the world, and experience an array of new products and techniques that will advance ear, nose, and throat care for our patients. Dr Mark Wax and his team have selected hundreds of papers and panels for your education, and many of those studies will be published in this journal over the coming year. Please consider meeting our associate editors at the interactive tables scheduled throughout the meeting. I offer a few of our representative papers here to whet your interest in this September issue.

In our first manuscript, Lam and colleagues examine the relationship between tonsil size and drug-induced sleep endoscopy (DISE) in determining polysomnographic outcomes of adenotonsillectomy in children.1 The authors studied 36 children with a mean age of 6.8 years who underwent adenotonsillectomy for a diagnosis of obstructive sleep apnea or sleep-disordered breathing. They evaluated the effect of both tonsil size and dynamic collapse of the upper airway on change in polysomnographic outcomes after surgery. On the basis of their analyses, the authors determined that while tonsil size and DISE assessment were strongly correlated, awake tonsil size was not associated with change in polysomnographic parameters, while sleep endoscopy scores on DISE were significantly associated with this change. Lam and associates conclude that in children at risk for adenotonsillectomy failure, assessment of dynamic collapse with DISE may better predict the outcome of surgery than awake tonsil size assessment. They conclude that these observations are beneficial in setting expectations with parents on the success of adenotonsillectomy in these children.

In our second paper, Du and colleagues assess the effects of a multimodal analgesic plan on opioid requirements and pain control in patients undergoing head and neck surgery.2 This protocol included the use of acetaminophen, ketorolac, and pregabalin for all patients, with opioid prescribed on an as-needed basis. The primary outcome measure in the study was opioid use in the first 24 hours after surgery, with additional assessment of overall opioid use during hospitalization. The study compared 139 patients treated after implementation of this protocol with 89 patients who underwent surgery prior to the protocol. The authors observed a significant reduction in opioid use in the first 24 hours after surgery; however, this reduction was not noted over the entire length of stay. Du and associates discuss the implications of their findings and note that while initial reduction in opioid use can be obtained, additional studies are necessary to refine the overall analgesic strategy in patients undergoing head and neck surgery.

In our third manuscript, Seligman and associates assess the decannulation rate among children undergoing tracheostomy with a standardized decannulation protocol.3 In the authors’ approach, children have a standard tracheostomy tube replaced with a fenestrated tube, which is subsequently capped prior to attempted decannulation. In addition, the protocol utilizes pulse oximetry rather than polysomnography for decisions about decannulation. Using this standardized protocol, the authors attempted 26 decannulations on 23 patients and noted failures in 4 patients, for an overall failure rate of 15%. On the basis of these results, Seligman and colleagues observed that their success rate was similar to other published results, with a lower resource utilization by applying results from pulse oximetry rather than polysomnography. They discuss the implications of their study for care of these children.

In the fourth paper, Berge and colleagues evaluate the association between hearing thresholds and postural balance among patients presenting with symptoms of dizziness and suspected for peripheral vestibular disorder.4 In this study, the authors examined a cohort of 1075 patients using audiometry and postural sway assessment. They then compared pure tone average hearing thresholds in the better-hearing ear with postural sway path length after correcting for age and sex. Analysis of the authors’ data demonstrated that increased hearing threshold was a strong predictor of postural sway, with a 10-dB increase in hearing threshold predicting a 6.0% increase in sway path length. Of the covariates, increased age and male sex were also significant predictors of increased path length.

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increased hearing threshold remained a significant predictor of postural sway after these covariates were considered. On the basis of these findings, Berge and associates conclude that increased hearing threshold in the better-hearing ear is an independent predictor of increased postural instability and that unilateral vestibular dysfunction does not appear to explain this association. The authors also discuss the implications of these findings, including the importance of patient education to reduce fall risk.

Finally, Chen and colleagues examine end-of-life care in patients with head and neck cancer and early versus late enrollment in hospice care. Using data from the Optum database, the authors identified 88,834 patients with head and neck cancer, 560 of whom had hospice cost data available in the database. Among a final cohort of 314 patients with complete data, the authors noted that the median length of stay in hospice was 16 days. In patients with hospice stays <3 days, overall costs of care were significantly higher than those of patients in hospice ≥3 days ($37,426 vs $24,418). The largest portion of this difference was related to inpatient hospital care, with nearly one-fifth associated with the use of radiation therapy. While the study did not examine quality-of-life (QOL) outcomes among these patients, the authors cite evidence that appropriate use of hospice placement and palliative care services can improve overall QOL. Chen and associates discuss the implications of these data and stress the need for additional research that can develop protocols to both improve QOL and reduce overall costs among patients with end-stage head and neck cancer.

Thank you again for reading this September issue of *Otolaryngology–Head and Neck Surgery*. I look forward to seeing all of you in the Big Easy this month. Safe travels!

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References