Welcome to November. We just celebrated a haunting Halloween, and now Thanksgiving is creeping up steadily and surely. The holiday seasons always bring us times of joy and anticipation. They give us opportunities to enjoy long days with friends and family and hearty meals that invoke memories of childhood. In that holiday spirit, I would like to present 5 papers from our November issue to read in those moments between conversations, dinners, and football games!

In our first paper, Henry and associates perform an important study that investigates suicidal ideation, suicide attempts, and completed suicides during the first year after diagnosis among patients with head and neck cancer (HNC).1 The manuscript examined 223 patients who were within 2 weeks of their initial diagnosis of HNC, using both psychometric instruments and structured interviews to assess suicidal thoughts. Patients were also followed over 1 year to assess suicidal behaviors. The authors noted that suicidal ideation was present in nearly 16% of patients newly diagnosed with HNC. Further, 0.9% of patients attempted suicide, and 0.4% completed suicide in the first year. Two discrete predictors were significantly associated with suicidal thoughts and actions in this population: prior psychiatric illness and substance abuse as a method of coping. Henry and colleagues comment on these important findings and stress the need for suicide assessment and prevention as routine care for all patients newly diagnosed with HNC.

In a related paper, Cramer et al examine pain and quality of life among survivors of HNC ≥1 year after initial diagnosis.2 The authors identified 175 patients at a median of 6.6 years after diagnosis, among whom 45.1% reported persistent pain and 11.5% reported severe pain. Among those patients with pain, 46% reported poor quality of life, in contrast to 12% of individuals without pain. Multivariate analysis demonstrated that pain was more common among patients managed with trimodality treatment and was significantly associated with major depression and anxiety. The authors note the significant problem of pain, even years following diagnosis and treatment for HNC, and stress the need for future therapies to concentrate on methods of alleviating and mitigating pain during management of HNC.

In the third paper, Plodpai compares endoscopic overlay tympanoplasty (EOT) with microscopic overlay tympanoplasty (MOT) in the treatment of patients with large tympanic membrane perforations.3 In this study, the author examined 70 patients who were randomized to receive either EOT or MOT for closure of their perforations, and the primary outcome measure was pain associated with the technique. In addition, the author assessed the closure rate of each group. After treatment, 34 EOT and 30 MOT patients were followed for 12 months, and pain was assessed over the first 48 hours. The author noted that there was significantly less pain with the EOT procedure when compared with MOT, and closure rates were 97.1% and 93.3%, respectively. In addition, postoperative air-bone gap was less in EOT. Plodpai discusses the advantages of EOT in terms of pain, healing, and audiometric outcomes and suggests its primary role in treatment of large tympanic membrane perforations.

In the fourth manuscript, Kita and colleagues evaluate the use of a point-of-care test for the detection of cerebrospinal fluid (CSF).4 Using standardized, titrated samples of CSF, the authors utilized a bar-coded immunoassay procedure to semiquantitatively identify small amounts of beta-trace protein within and below the level of 1.3 mg/L. Clinimetric analysis of the procedure demonstrated excellent utility and suggested that the method could provide immediate diagnosis of CSF leakages in skull base surgery. Kita and associates discuss the novel procedure and note the need for additional studies to validate the method in clinical practice.

In our final manuscript, Kaufman and associates assess the demographics, indications, and outcomes of patients receiving awake versus sedated tracheostomies.5 The authors identified 978 patients in a single institution who underwent tracheostomies over a 34-month period. Of these procedures, 78 were performed on awake patients. The authors noted that the major reason for performance of an awake tracheostomy was the presence of an upper airway malignancy. They noted that there was no significant difference in mortality among patients undergoing awake versus sedated tracheostomy. The authors note that there appears to be no significant difference in overall adverse events among patients undergoing these 2 procedures. They discuss the implications of their findings.

1School of Medicine, University of Texas Rio Grande Valley, Edinburg, Texas, USA

Corresponding Author:
John H. Krouse, MD, PhD, MBA, University of Texas Rio Grande Valley, 1201 W University Drive, Edinburg, TX 78539, USA.
Email: john.krouse@utrgv.edu
Thank you again for reading *Otolaryngology–Head and Neck Surgery*. Please enjoy these highlighted 5 papers and have a wonderful Thanksgiving!

John H. Krouse, MD, PhD, MBA
*Editor in Chief,*
Otolaryngology–Head and Neck Surgery
Dean, School of Medicine,
*University of Texas Rio Grande Valley*
Edinburg, Texas, USA

References