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Balloon Eustachian tuboplasty, revision sinus surgery, mental health in paediatric cochlear implant patients and medico-legal aspects of laryngoscopy

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Editorial

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The consent process for patients undergoing any surgical procedure has evolved in recent decades, with the Montgomery case resulting in a quantum shift in what we are required to discuss with patients. Whilst a good consent process does not protect a surgeon from the effects of poor practice, it can improve outcomes because the patient should have a better understanding of the possible or probable results. With new procedures such discussion is more difficult and this issue of *The Journal of Laryngology & Otology* contains a review paper from Leicester and Peterborough (UK), this issue's 'paper of the month', which evaluates complications of balloon Eustachian tuboplasty.[1] The procedure has been available for well over a decade and aims to dilate and open the cartilaginous part of the Eustachian tube to improve dysfunction. This has been the topic of many *Journal* articles in recent years.[2,3] The complication rate of the procedure is low (under 2 per cent), with the most common complication being surgical emphysema (0.4 per cent). As we are required to discuss with patients any 'material' complication, as well as serious ones, this paper should be examined carefully by anyone undertaking this procedure. Particularly noteworthy is a case of asystole, which thankfully was successfully reversed, and was thought to be due to a neurally medicated vagal reflex. The authors recommend avoiding the Valsalva manoeuvre after surgery, avoiding exertion, use of prophylactic antibiotics and measures to avoid mucosal injury.

Revision sinus surgery happens much less often than in the days of repeated nasal polyposis, but is acknowledged to be riskier than primary surgery, so risk factors for needing these interventions are of interest.[4] This issue has a paper from Izmir (Turkey) which retrospectively examines clinical and radiological risk factors and their relation to phenotype.[5] The results were largely predictable, reminding us that patients with aspirin sensitivity, asthma and an eosinophilic pattern of histology are more at risk of the need for revision than other groups. The Lund–Mackay score and osteitis scale did not feature as factors, which was surprising but might be explained by the heterogeneous nature of the sample.[6] The authors recommend that patients falling into high-risk groups should have their surgery in major centres with all appropriate technical and pathological facilities.

As cochlear implantation becomes more common in adults and children, and the indications widen audiologically, it is necessary to justify surgery from many different quality of life indices.[7] Mental health seems like a sensible component of this evaluation. This issue has a paper from Lanzhou (China) which examines the mental health of 82 paediatric cochlear implant recipients,[8] as assessed by a mental health survey questionnaire for 3–6-year-old children adapted from a previous US developmental questionnaire. The authors found that children who received implants earlier than others had better mental health scores, which indicated better rehabilitation after surgery.

One good piece of news regarding consent and litigation comes from Philadelphia (USA) in relation to litigation after laryngoscopy.[9] Good informed consent and proper technique were found to reduce litigation risk, and those cases that went to trial tended to favour the laryngologist (defendant) rather than the claimant (patient). The same luck did not apply to anaesthetists, as peri-operative dental injury accounted for a third of all claims against that specialty.

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