Vote early and vote often

Tony Narula

Having been elected to the Council of the Royal College of Surgeons in 2004 it is time to take stock of what is going on in the medico-political landscape as I seek re-election in early 2010.

EWTD

Members of ENT-UK will have seen acres of comment on this issue. Especially from the President of the RCS John Black. I have fully supported his stance that rules introduced to protect truck drivers or production line workers are not appropriate for professionals. On the other hand no-one can deny that in certain specialties (eg Emergency Medicine, Obstetrics) prolonged hours are unreasonable. But for most surgeons (including ENT) a maximum of about 60 hours on call allows avoidance of shifts (which are universally hated) and also time to gain enough experience – especially in emergencies. This figure chimes with experience from the USA and Germany. What has been sad is the failure of other major Royal Colleges to publically align themselves with the RCS – whatever they may have said in private. Interestingly the College of Emergency Medicine have said they cannot sustain a 24 hour A&E without a surgical presence. Currently it appears that many hospital rotas are shams with unfilled posts in order to be EWTD compliant and increasing problems filling these rota gaps as locums seem to have dried up following the change in immigration rules last year.

SAFETY

Patient safety is the new buzzword being used by everyone from Sir Liam Donaldson downwards (upwards?). It’s a bit like motherhood and apple pie: everyone is in favour of this but being in favour doesn’t make it happen. All sorts of new institutions have sprung up like the National Patient Safety Agency to protect the public. Revalidation also comes into this (see later). In fact Safety will become a fig-leaf to close hospitals. The CEO of the NHS has said quite explicitly that he wants to transfer huge swathes of activity into the community and that hospitals will have to ‘change’. As Safety/Quality are mentioned more and more we can predict some consequences. For example the arrival of designated ‘stroke’ centres means that not all existing hospitals will take unrestricted emergency referrals. This is in conjunction with the related major trauma centres. Thus if your hospital is not in either category your A&E is at risk and soon thereafter your acute status in general is at risk. That will swiftly be followed by downgrading to a community hospital with large budgetary savings as staff will no longer be required at previous levels.

REVALIDATION

Many of you will know that I am
the RCS revalidation lead. Each specialty is working hard on this to set appropriate standards and describe the measures of attainment to those standards. In practice the DH is uncertain of the point of revalidation: sometimes it is to prevent another serial murderer (Dr Shipman) and at other times it is to enhance safety and quality of patient care. Without a clear statement of aim it is hard to see how this innovation will make it into our patients. One can however predict the risk of a massive increase in bureaucracy. Sometimes I just think a 5 yearly exam would be simpler: that’s a measure of how worried I am about this topic, not because I think an exam is a good idea.

QUALITY ACCOUNTS
All NHS Trusts will have to publish quality accounts in the near future. I have looked at the draft standards and am afraid that this is just another box ticked. The standards are high quality as a smokescreen. If it means re-introduction of Performance Indicators by another name it is a regressive step. As always, if you make it important enough we can work something to this. It seems to me that this is a good idea.

QUALITY ACCOUNTS

Managers—don’t you just love them?
Ray Clarke

Contact with ‘twenty-some-thing’s’ is hard to come by at my age so I am always glad to see the medical students. They update me on the soaps, the X factor and the perverse selection process for Foundation Programme jobs. They tell me about their every-day-earner, their elective in the Seychelles, the best nightclubs on Merseyside and where the twenty-four hour shops can be found. I get to hear of the prohibitive cost of apartments on the docks and of how tough it is when you have a mod-est sports car and a vibrant nightlife to run on nothing but a measly and grudging parental supplement and a student loan. In return they get to lis-ten to a grumpy old curmudgeon going on about the latest crazy management initiative, what a disgrace our politi-cians have become, how hard we all work when I was a junior, and how only one lad in our class–now an emi-nent professor of surgery–had a car and we all had to cadge lifts off him in return for either lecture notes or pints of Guinness. If we are on a good run in clinic and there is extra time I get them to take some of the histories, show them how to use an auriscope, and dispense the odd pearl of wisdom, all the while peering at them over the rims of my reading glasses. It’s a win win really.

I was hesitant recently when the clinic manager asked me if I manage a student could sit in my clinic. A medi-cal consultation after all is a private encounter, patients don’t always want an unqualified observer listening to their medical histories–hence I always ask if they are happy to have the stu-dent doctor present. How would they feel about a non-clinical student? Worse still, one who was planning to be a manager? After some thought I agreed. I then reflected on the unspoken camaraderie that we medics enjoy, and on how it extends to medical students, who are seen as part of the ‘club’ at a very early stage and are privy to intim ate details relating to patients. Non-meds, rightly or wrongly, sometimes see this camaraderie as insular, elitist, and hostile to “non medics”. I.e. ‘this lot all stick together’. Health service managers tell me they feel this very acutely; it can make for an uncomfort-able barrier to working relationships with us. I needn’t have been too con-cerned about privacy as patients univer-sally agreed to have a management trainee sit in on their consultation–many thanks for it a novel and long over due initiative.

Whisper it softly, I don’t want the medi-cal director to know I have occasioned any quiet moments in clinic but in some of these quiet interludes the young lass patiently sitting in with me explained that she was on a graduate training programme for aspiring NHS managers. A first-class honours economics gradu-ate, she had come through a gruelling three day selection process that sounded as if it was modelled on ‘The Apprentice’. She must have been scarily clever as the ratio of acceptances to places was a staggering seventy to one. The training programme as she outlined, involved rotating appointments in various trusts, on-the-job training, shadowing senior managers, some classroom-based teaching on NHS fi-nances, commissioning, providing services and a good deal of exposure to clinical practice–hence the clinics. She will do a series of rigorous assessments and gain a postgraduate qualification in health service management. She was as enthused and excited about the pros-pect of improving patient care as were any medics I have ever taught. I know it is fashionable–almost a rite of passage–for us doctors to sneer at managers and assume they are unfeeling, devilish, horned creatures whose ‘raison d’être’ is to save money, obstruct medical initiatives and en-courage themselves in plush offices where they are insulated from the coal face of clinical encounters. Isn’t it us doctors who have a monopoly on em-pathy and caring, looking after pa-tients, responding to their needs, advo-cating for them, driving services for-wards, and keeping the nasty managers out of our conspirational rapport with patients? Well, no, it isn’t and we don’t. Medical graduates – like humanities graduates and everybody else–can be remote, self-absorbed, belligerent, stubborn, mendacious, duplicitous, manipulative and venal. Managers don’t have exclusive call on these qualities. Many managers–as is the case with many doctors–are exceptionally compe-tent, idealistic, committed, and care deeply about improving the lot of pa-tients. It will pay dividends for us all if we nurture, encourage, train and re-ward them. We should support and advocate graduate training schemes that ensure the most talented of our youngsters think about NHS careers rather than being seduced away by large salaries in the city, retail, and banking. Even more pertinent for us, we –and our mates– can profit from working closely with our managerial colleagues, particularly in the challeng-ing economic times ahead. Despite the denial of previous claims of politicization, we were the only doctors that you can maintain and expand “frontline” NHS services but make massive cuts in administrative costs by sacking managers, any NHS accountant will tell you that the poten-tial for making savings in this way is very marginal indeed. By comparison with senior managers in other arenas—including most parts of the public ser-vice–NHS managers have very modest pay packages. No organisation can prosper without good managers. Like it or not we need administrators, secre-taries, clinic co-ordinators, theatre supersimos, service directors and senior executives to steer improvements for ward. We need non-clinical as well as clinical leaders of the future, and it behoves us all to work produc-tively and openly with them.

Make friends with your manager; he or she could help you through some very rocky times ahead.
Procedure Based Assessments (PBAs)
Andrew Robson

Part of the assessment process for the Intercollegiate Surgical Curriculum Project (ISCP, islcp.ac.uk) is the requirement to perform Work Place Based Assessments (WPBAs) to demonstrate progress to competence in various domains of the syllabus. Theses assessments should take place in a formative manner (they are assessment for learning rather than assessment of learning). The WPBAs are: Case Based Discussion (CBD), mini Clinical Evaluation Exercise (mini-CEX), Direct Observation of Procedures (DOPS) and Procedure Based Assessments (PBAs). The latter have been devised to assess competence in performance of surgical procedures. They test competence at all aspects of a surgical procedure, including understanding of indications, consent, preoperative preparation, surgical technique and postoperative care.

There are two aspects to PBAs: generic aspects and procedure specific aspects. The generic template can be modified to make it applicable to specific procedures. For example whilst one item refers to preparing the skin appropriately for an incision, this is clearly not applicable for any ENT procedures, for example tonsillectomy; this item can be omitted from the PBA to make it more applicable.

Currently there are 11 ENT PBAs (some applicable ones can be found in other specialties’ syllabus). Whilst very useful for assessment these do not cover enough of a range of ENT procedures to ensure meaningful formal assessment of the surgical aspect of the curriculum to take place. Other specialties have many more (e.g. paediatric surgery has 57 and urology has 26) which make them a more versatile and useful tool for assessment.

41 further PBAs relevant to ENT have recently been written, and the current ones updated, in order to map them more appropriately to the curriculum. They cover both elective and emergency procedures in all aspects of the specialty. It was agreed by the SAC that, in line with ISCP requirements, surgeons should have the opportunity for piloting the draft PBAs so that modifications can be made prior to implementation. The draft PBAs were therefore sent to all otolaryngologists on the NAPDENT website with the request to pilot them with their trainees over the next few months. Any modifications will then be discussed and incorporated into the PBA. These would then be adopted and placed on the ISCP website for use in assessment of training.

The idea is to use them ‘real time’ so that the trainees can work to a structure. The trainer should feedback back, their assessment identifying strengths and development needs with an action plan if necessary. Feedback should take no longer than 5 minutes and can easily be carried out between cases in theatre. Using the PBAs during the pilot will effectively identify improvements for adoption, so the more people who do this, the better!

The draft PBAs should be available from your programme director and other training representatives. Please use them and make comments that may help improve their standard. Please feedback any comments to your programme director or direct to myself at awrmk.robson@virgin.net.

We plan to discuss adoption at the next SAC meeting on March 1st 2010 so I would be grateful for comments to come in before then. The next step will be to update and archive the DOPS portfolio for ENT.

Notes

CHAMPAGNE RECEPTION AT THE ANNUAL MEETING IN WARWICK 2010

The President is hosting a champagne reception for newly appointed Consultants and those recently retiring. This reception marks the two most important Rights of Passage in a Consultant’s career and is an occasion not to be missed.

Invitations will be extended to those appointed as Consultants between September 2009 and September 2010. If you know of anyone to whom this applies, please let Nechama know. Those who are retiring around these dates should also let the office know. It is said that retirement is a time when you become too busy to work, but it is hoped that as many as possible will make the time to meet the people who will be following in your footsteps.

MEDICAL TRAINING INITIATIVE

Registrars, soon there could be an international medical graduate on this scheme working with you. I am sure you will make them welcome and help them acclimatise to the wonders of the NHS. The MTI is providing Tier 5 training visas for a maximum of 2 years specialist training in the UK. These posts are at ST3 level and above and utilise the training being made available when the National Training Numbers reductions over the next few years. We will be welcoming the brightest and the best from many countries who can return home with valuable skills and experiences, and hopefully life long friendships.

Independent practice survey
Tony Jacob

To clarify what is current ‘normal practice’ in our specialty, under the auspices of the IPC and EN'TUK, we undertook a survey of all consultants in the UK earlier this year. Just over 50% of all practicing ENT Consultants responded and of those over 96% undertake some private practice. Almost 14% now practice in a partnership or group model of some sort. A third of practitioners have a web presence and therefore in one way or another market their services.

Comment: The figure of 96% may represent a bias as those that do not undertake any private practice may have chosen not to participate in the survey. The number of partnerships in play has risen and there are a wide variety of models out there. Anecdotally it would also appear that those in groups have noticed a stability of income, if not an actual increase in the last few years.

A large percentage (40%) have noticed a drop in income over the last 3 years. 55% of those surveyed earned below £100k per year with about 10% earning well over £300k. On average a new patient consultation was charged between £125 and £175 (70% of respondents) and most (89% of respondents) charged just under £125 for a follow up visit.

Comment: As seen in the 2003 survey there is wide geographical variation in charges reflecting overheads and market forces, so it is very difficult to determine an ‘average consultation fee’ that is applicable across the country and perhaps what we should accept are ‘regional averages’.

Choose & Book services - on average the fee for a new consultation is between £25 and £75 with the follow up fee considerably less! The vast majority did not receive any remuneration for outpatient procedures (eg ear micro suction).

Comment: Seeing NHS patients in the private sector is underpaid. The practice also polarizes views – there are those who believe it is a good use of ‘spare capacity’ in the private sector whereas others firmly believe that it muddies the water for very little return.

More than half of our respondents participated in NHS waiting list initiatives, carried out in the NHS or in the private sector. A session – a 4 hour slot, was remunerated at £600 or more for the majority of respondents. Comment: These figures should help inform (local) negotiations for those who are remunerated at a lower level.

In our outpatient clinics, 95% would charge separately for procedures done in the clinic such as microsuction of the ears and flexible nasendoscopy and most do so using the BUPA rates as a guide. The vast majority (82%) would not charge additional fees when using topical local anaesthetic.
Comment: While it seems perfectly appropriate and normal practice to charge for additional outpatient procedures, the idea of a groundswell against charging for the administration of topical anaesthetic.

The survey showed that on average 2% of our overall activity is through intermediaries such as Alliance Surgical.

Comment: However this is not the true picture. As most of the majority did not do work from intermediaries at all. There was a small number of consultants for whom it made up 25-50% of their private income and for one respondent it made up 99% of his income thereby skewing the overall results.

It was also shown that approximately 30-40% of our in-patient surgical incomes contain multiple codes.

Comment: This too is an important point to note in a time where more and more insurers are accusing doctors of "unbundling" when in fact it probably reflects the complexity of procedures and also ambiguity in existing codes.

The majority of respondents (76%) said they would be opposed to reverting to billing the patient directly (rather than the insurance company) thereby maintaining the patient-doctor relationship and reinforcing the fact that the patient is ultimately responsible for settling voices.

Goodbye to All That
Adrian Drake-Lee
SAC chairman

"Where have all the young men gone, long time passing?" Pete Seeger, Where have all the flowers gone?

"How many roads must a man walk down before you call him a man?" Bob Dylan, Blowing in the Wind

I learnt these songs in the early sixties. At the time I did not know that the tunes were borrowed from the folk tradition: the words rang true to me. They do still. Life was changing and I was going over the top into no man’s land. That is what it feels like again as I say goodbye to everyone. I know that within three months people will ask, ‘Who?’, life moves on.

I visited the RNTNE hospital a couple of years ago. I was a registrar and senior registrar there and my approach was to get all the trainees involved. I ran the journal club and found projects for the other doctors because I have always been able to see opportunities. My only tangible mark was to get the registrars a room to work in and there it was still when I visited. My involvement was unknown to those using it.

I have grandchildren and a son who is a last survivors of the Great War are gone. One of the people who helped out in the early years autobiography by Robert Graves was one that I have read three times, once at school, again at university and finally a couple of years ago. I got something different out of each time. When I was growing up, the people around me had been involved in either the First or Second World War. The woman who helped look after me had lost her fiancé in the First War. One of the people who helped out in the garden spent two years getting over his infection from a bullet in his left arm when he was wounded in 1916 at the battle of the Somme. My parents fought in the Second World War. The last survivors of the Great War are gone and my parents’ generation is dying. I have grandchildren and a son who is a Foundation doctor facing his career choices.

I would like every trainee to be career now, one never knows. But now the answers is obvious, protest carols on the guitar recently. I won’t go on, I have been learning to finger pick Christmas songs. Perhaps I will have another career now, one never knows.

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English college council report 2009

Chris Milford

This is a brief update on the College Council business over the past few months. I hope the following may be of some interest to you as surgeons ‘at the coalface’:

Recertification – the College has worked closely with ENTUK to set standards for the Specialty. All doctors on the specialist register will need to demonstrate they meet standards that apply to their medical specialty in order to be recertified (Tony Narula is the College lead in this area and I am sure he would be happy to provide further information if you contact him). The Department of Health have identified six sites where pilots for surgery may be conducted (including teaching and non-teaching hospitals). Phase 1 College piloting will begin in June 2010 and will be completed by March 2011. Implementation for piloted specialties could therefore potentially commence in the second quarter of 2011. Phase 2 pilots for remaining specialties would begin in the second quarter of 2011 (although there has been significant ‘slippage’ in this project already and it would not surprise anyone if implementation did not start until 2012 or later!).

The English College e portfolio (designed to help surgeons record the data required for their appraisal/recertification) has been ‘soft launched’ on the website i.e. it is available but may still undergo some changes depending on the feedback provided regarding its ease of use.

e portfolio/logbook – there has been an ‘outbreak’ of common sense regarding the ongoing ‘fight’ between the English & Edinburgh Colleges over the development of a portfolio for surgeons to use for appraisal/recertification. As you know the majority of ENT surgeons use the Edinburgh logbook, the trainees have been told they must use the ISCP English College logbook and both Colleges are developing an e portfolio. There is now a ‘will’ to produce a joint product that all members/fellows of both Colleges will use – negotiations continue about how this is achieved but the belief is that an agreement will be reached in 2010 to produce such a product.

SPA/PA ratios in new job descriptions – as Council lead for the Advisory Appointment Committees, I have been involved recently in dealing with several new job descriptions which have not conformed with the 2.5 SPA/7.5 PA ratio that was negotiated by the BMA in 2003 (several jobs have been reviewed by Regional Specialty Advisers in different specialities with ratios of 1.5 SPA/8.5 PA or 1 SPA/9 PA). I have discussed this issue with the President and it was discussed at the December Council meeting. I have been asked to liaise with the BMA and the College of Emergency Medicine (who have already refused to recognise any job description without a 2.5 / 7.5 split) and then pro-

ENT UK charitable donations and “The Giving Machine™

Andrew Swift

Several weeks ago during an executive meeting I became aware of a completely new term that I had no idea about – the words were ‘The Giving Machine’. Alan Johnson directed a short discussion in which I tried not to look too bemused, and then turned to me with the words ‘Andrew, can you lead on this one!’

After a few nights of feeling as if I should learn to keep up, I soon became aware that I was not the one with the understanding about this topic. However, after a little research I rapidly started to grasp the concept and the guidelines for the website soon followed.

Quite simply, ‘The Giving Machine’ provides a means of raising charitable donations by internet shopping. The Giving Machine portal can easily be downloaded as a red heart onto your internet toolbar. When the portal is entered, you are directed to an online shopping site in which there are over 200 leading brand names. If you purchase goods or services from any of these brand names, a percentage of the total money spent is pledged to a charity of your choice. ENT UK is registered with the list of charities and can be set as the charity to which all funds are directed during the simple registration process.

The concept of the site is to minimize the overheads incurred in collecting charitable donations and to encourage small but frequent donations. The site is very easy to navigate and retailers are easy to find. There is in fact a wide range of retail possibilities that include banking, insurance, food shopping, theatre tickets, flowers and holidays. The percentage that will be donated to charity from each purchase is clearly displayed by each retailer: most donations are in single figures but some are substantial and exceed 20%.

Once you register with ‘The Giving Machine™’ and set your choice of charity to ‘ENTUK’ the donations will be sent directly to our own charitable fund with each internet purchase. The process is to be started by supporting a single charity and we are appealing to members to provide suggestions as to what should be.

A guidance note that further explains “The Giving Machine™” site is now on the ENT UK website. Your help and support with our fund-raising project would be gratefully valued and with Christmas coming, this is the ideal time of year to start. Happy spending.

On the other hand- BACO fees

Chris Pearson

Sal Nair (ENT UK Newsletter, October 2009) invites debate concerning whether or not invited speakers at our conferences should pay their own way: I fear that he may find little sympathy for his viewpoint amongst the wider membership.

Invited speakers make their reputations by virtue of their presentations. Although this may be difficult to quantify in monetary terms (other than by clinical excellence awards), it undoubtedly has value for them. Why then should speakers not pay for the privilege of speaking? Normal practice requires those who present free papers or posters for conferences. The vast majority of these are trainees, on lower incomes and without the ability to offset their expenses against tax. Why should they be the only ones who pay in order to attract an audience? Mr Nair suggests that a number of first-choice speakers had declined invitations to BACO. I had no reason to believe that those who did speak were second-rate. I have noticed that conferences often include the same speakers year after year. This may well impose a financial burden upon them, but there must be many other worthy colleagues who would be happy to present their work. Might the prospect of fresh faces, with new ideas, not attract more delegates? Famous keynote speakers and eponymous lecturers (for example Hunterian Professors) are of course a different matter, but I humbly submit that ENT UK is fully entitled to ask us to pay our way on equal terms.

Vol 20, No, 1 Page 5
Role of surgery in treating glue ear

The only effective intervention for treating childhood hearing loss caused by glue ear (otitis media with effusion; OME) is the insertion of grommets, (ventilation tubes). In selected cases removal of the adenoïd from the back of the nose, adjacent to the Eustachian tube opening (which allows air pressure equilibration) is also recommended. Grommet insertion and adenoidectomy work by reducing low grade infective biofilm load in the back of the nose, and causing a massive increase in oxygen tension in the middle ear; this in turn, further inhibits inflammation mucin gene activity and hence the formation of middle ear fluid (glue). Most grommet and adenoid procedures are carried out as day cases with very little systemic morbidity or risk.

Intervention criteria

In 2008, the National Institute for Health and Clinical Excellence (NICE) published guidance following expert statistical and health economic review of the optimum international scientific evidence (CG60, Surgical management of OME). NICE states that children who will benefit from surgical intervention are those with persistent bilateral glue ear, documented for a period of 3 months. A hearing level in the better ear of 25-30 decibels hearing loss or worse, averaged at 0.5, 1, 2, and 4 kHz. (For reference, a 16 to 25 dB hearing loss may be mimicked by plugging the ears with the index fingers). At even 16dB, a child can miss 10% of the speech signal even when the listener is 4 feet away. Thus, in a classroom environment, a 25 - 30dB loss presents an appreciable educational difficulty.

The rate of UK surgical intervention for childhood glue ear has fallen steadily over the past 15 years. Adenoïdectomy rates fell dramatically in the late 1990’s from over 16,000 procedures per annum, and in 2008-09 there were 5529 adenoïdectomy operations in children <15 years. Childhood grommet insertion has also fallen from over 43,300 operations in 1994-95 to under 25300 in 2008-09 – a 42% reduction, largely due to the better understanding of the natural history of glue ear and the role of ‘watchful waiting’.

Watchful waiting or ‘active monitoring’

Watchful waiting is now recognised as an essential, preliminary period of observation with monitoring of hearing loss. The research by ENTUK surgeons, funded by the MRC (the TARGET multicentre trial) has shown that 50% of children with a bilateral hearing loss of at least 20dB are likely to recover to normal with no treatment in the first three months after diagnosis. The remaining 50% with persistent hearing loss, concerns about speech, language or other associated problems are those potentially eligible for surgical intervention. In the persistent cases, of course, surgical intervention is inevitably delayed by this watchful waiting policy, leading to concerns that the UK surgical cut backs imposed over the last decade might have been excessive, driven by cost-cutting rather than clinical evidence. This was the finding in Australia, where an independent medical investigation concluded that there was now actually an under-utilisation of ear nose and throat surgery in children - i.e. children requiring surgery were going untreated.

Limitations of RCTs of surgical intervention due to parental choice

The UK TARGET study was a randomised trial design of surgical treatments for glue ear versus non-intervention, and final results reporting is imminent. The delay in the MRC team’s publishing the overall trial outcome is partly because almost 60% of children with glue ear who were randomly selected into the ‘no-surgical treatment’ limb were switched out of the nonsurgical group by their parents, who decided their children should undergo surgery rather than suffer continuing hearing loss for the purposes of the research study. In other studies of similar high quality, up to 85% of parents of children allocated to the ‘no treatment’ group requested a move to the treatment group.

The fact that parents tend to switch children out of no treatment into surgery for glue ear has two important implications. Firstly, of course it underlines the level of concern and the recognition of the effectiveness of surgical intervention on the part of parents. Less obvious, but equally important is the fact that not all studies properly report the results according to who switched from no surgery to have surgery. The statistical impact of this habit is to underestimate the difference between the surgery and no surgery groups, as those gaining surgical benefit continue to be analysed as part of the no treatment group.

Implications for children of severe rationing of surgery for glue ear

ENTUK is therefore alarmed to learn that non-medical ‘consultants’ on Health Service resource allocation have recently stated that the treatment of children’s hearing impairment is largely ‘unnecessary’. One problem for commissioners scrupulously reviewing the results of surgery is that sound is measured by the decibel scale which is logarithmic; the 2005 Cochrane review showed about 9dB improvement from grommets in the first six months after operation, 6dB in the next. The raw numbers look unimpressive – but due to the logarithmic decibel scale, even a 3dB increase in sound equals to a doubling of intensity and hearing sensitivity. After 12 months there is predictably little residual difference, in some series, between treated and control groups, as the hearing in both groups is now normal. Most parents (and teachers) do not want a child to spend a year in a school classroom with sub-normal hearing.

Many other quoted studies include no hearing test data, as the children recruited were too young to perform the test. In this context, early, active management is supported by the testament of adults with glue ear, who regularly present for treatment and well articulate the daily functional impact of a middle ear effusion. Any specific rationing of children’s glue ear treatment, imposed by public health policy, would appear to represent a form of age discrimination favouring adults at the expense of children. Earlier this year, McKinsey submitted a vision of wholesale withdrawal of 90% of NHS funded surgical treatment for hearing-impaired children (Table 1). ENTUK is concerned that there is no scientific basis for selection of the 10% of English children still in future to be judged ‘worthy’ in the eyes of the management consultants to receive definitive therapy. Parents, paediatricians, audiologists and otolaryngologists do not want children to be disadvantaged. The surgical alternative – to provide all children with glue ear with NHS digital hearing aids is neither cheap for providers nor acceptable to the vast majority of service users. Health economic modelling by NICE is fanciful in its speculative and evidence-free cost estimation of this alternative. At the end of the day, most of us, given the choice, would prefer not to have to wear a hearing aid when a safe and effective day case surgical treatment fixes the problem as a day case procedure.

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Table 1

Extract from Table ‘Up to £700m could be saved if RCT’s decommissioned some procedures’: 2009 report by McKinsey management consultants commissioned by the DH, as published in the Health Service Journal, 10 Sept 2009

<table>
<thead>
<tr>
<th>Intervention</th>
<th>Max potential reduction in procedures (%)</th>
<th>Max potential savings (£m)</th>
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<tbody>
<tr>
<td>Tonsillectomy</td>
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<td>45</td>
</tr>
<tr>
<td>Back pain injections and infusions</td>
<td>90</td>
<td>24</td>
</tr>
<tr>
<td>Grommets (glue ear)</td>
<td>90</td>
<td>21</td>
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</tbody>
</table>
Indications for tonsillectomy - ENUK position paper

Janet Wilson and Alan Johnson

Introduction
This is a short paper produced by EN- TUK to define the current position of tonsillectomy as a surgical procedure in terms of the indications, predicted outcomes and benefits of surgery. This document is based on the available evidence and references are available to support its conclusions.

Description of Tonsilitis
Tonsilitis is an acute infection of the palatine tonsils. Episodes last for 5 to 14 days, during which the patient experiences some or all of the following: fever, malaise, nausea, severe throat pain, white spots on the tonsils, enlarged lymph glands in the neck (and sometimes abdomen). The attacks are common in children and their frequency may reduce with age, but the loss of time at school – usually 3 to 5 days per attack, several times per annum – can impact significantly on education. Tonsillitis is not as common in adults, but attacks can be as frequent and even more severe than in children and may cause significant loss of work due to illness. A severe complication of tonsillitis arising mainly in adults is peritonsillar abscess or quinsy, and this condition often requires hospital admission for treatment and pain control.

The cost of tonsillitis
The economic impact of tonsillitis is considerable. Annually, 35 million days are lost from school or work due to sore throats in the UK. GP consultations for sore throat cost around £60 million annually.

Indications for surgery
Tonsillectomy, the removal of the palatine tonsils, has three principal indications:

1. Recurrent attacks of tonsillitis (typically Streptococcal).
2. Enlarged tonsils causing obstruction of the airway, which may be the cause of Obstructive Sleep Apnoea – recurrent airway obstruction at night – and this has serious effects on health and wellbeing.
3. Possible malignant disease in the tonsils – typically squamous carcinoma or lymphoma.

For many years the UK guidance on tonsillectomy for tonsillitis has been only to consider surgery in those with attacks of at least moderate severity (several days’ duration) per annum, for > 1 year – the SIGN guidance summarises the current consensus.

Patients should meet all of the following criteria:

- sore throats are due to tonsillitis
- five or more episodes of sore throat per year
- symptoms for at least a year
- episodes of sore throat are disabling and prevent normal functioning

Those with very frequent infection (>8 per annum) or who are hospitalised with extremely severe tonsillitis or peritonsillar abscess (quinsy) may seek intervention within a year of symptom onset. Very similar guidance has evolved independently in the USA and Australia.

Changing practice
In the 1950s there were about 200,000 tonsillectomies performed a year. In the last 15 years the rate of tonsillectomy has fallen in all age groups from 77,604 in 1994-95 to 49187 in 2008-09, a 37% reduction. In children, the Department of Health identified almost 56,000 childhood tonsillectomies in 1994-95. By 2008 – 09 HES data show under 27,400 tonsillectomies in those aged ≤ 15 years. Of these, an estimated 25% were for enlarged, obstructive tonsils, the remainder for infection. In adults there were just under 22,000 tonsillectomy procedures in 2008-09, the majority for persistent tonsillitis. The reason for the reduction in the rate of surgery is because surgeons have used the data available to refine the indications for surgery so that the operation is now only offered to patients most likely to benefit.

Increasing hospital admissions for tonsillectomy and quinsy
There is now a risk that too few tonsillectomies are being carried out. An increasing number of adults and children are being hospitalised annually for throat infections. In 2000-01, there were 30,942 tonsil-related admissions for medical treatments. By 2008-09, the figure had risen to 43,641 medical admissions for throat symptoms, an increase of over 41% (12700 admissions in 2000-01, rising to 7683 in 2008-09, an increase of 1.331 million admissions per year – over 20%, with a total of 11865 bed days). Quinsy is an extremely painful and debilitating complication of acute types of tonsillitis, which requires introral drainage in the fully conscious patient, followed by admission for intravenous antibiotic therapy.

These conditions can be cured by tonsillectomy and as tonsillectomy rates fall it is predictable that hospital admissions for severe tonsillitis and its complications will rise, and this is borne out by the data available. Any further reduction in the rate of tonsillectomy is likely to be associated with increases in hospital admissions for tonsillitis.

Alternative treatment
Antibiotic treatment is the standard treatment for acute bacterial tonsillitis, but the evidence is that increasing this treatment is likely to be neither good medical practice nor cost effective. Recent UK analysis of a million cases of sore throat treated in the 1990’s showed a significant reduction in quinsy by the use of antibiotics – odds ratio 0.84 - but due to the relative incidence of sore throat and quinsy, the number needed to treat was 4300, and the use of antibiotics for all sore throats remains hard to justify. For recurrent sore throat, indiscriminate use of antibiotics by GPs is well documented as serving mostly to increase reattendance rates.

Benefits of tonsillectomy
Published data using generic and disease specific patient reported outcome measures on both sides of the Atlantic confirm the marked health status benefits in children. These include both significant benefits in the general health perceptions, parental impact and family activities reported by over 90% of parents. The quality of life benefits in adults are likewise unequivocal (large effect size improvements in health related quality of life, care utilisation, swallowing, and breathing, as well as general health related quality of life physical functioning).

About one in five tonsillectomies in England are performed for tonsilar enlargement, which is associated with Sleep Related Breathing Disorder (SRBD). SRBD (formerly classed as obstructive sleep apnoea) is a potentially life threatening condition and is the main indication for tonsillectomy in approximately 25% of UK children. Adenotonsillectomy is curative in 75 to 80% of cases of OSA. In the USA, the performance of adenotonsillectomy for obstruction has increased markedly in the past 30 years from 12% in the early 1970’s to 77% in 2000-05. It is to be hoped that national drives to promote healthy lifestyle in children will prevent the UK ever experiencing such an epidemic, as Sleep Related Breathing Disorder has a well documented, huge impact on childhood quality of life. The proportion of adults undergoing tonsillectomy for obstructive symptoms (21% in England in 2007-08) is under 10%, possibly due to lower levels of morbid obesity than in the USA.

Conclusion
Tonsillectomy remains a highly effective intervention in appropriate patients, not only in elimination of severe sore throats or upper airway obstruction, but also in terms of patient and parent reported quality of life. There are no data to suggest that the procedure is overused or abused in the UK. Tonsillectomy rates are lower in the UK than in any other country in Europe. In fact the trends of increasing hospitalisation for quinsy and severe forms of tonsillitis might indicate that rather than performing too many tonsillectomies in the UK, we are now performing too few.

References
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4 Little P et al Open randomised...BMJ 1997, 14: 722-7
8 Elglazi H et al Pediatric tonsillectomy...J Laryngol Otol. 2009, 123: 103-7
Just a short talk (at the RSM)
Liam Flood

As I write, it is getting near to Christ- mass and, so, to appraisal time, when annually, the gifts of whiskey are less important than the attached cards from grateful colleagues, now sans tonsils or turbinates. I sit in Kings Cross Station, wait- ing to depart from my very last SAC meeting.

December 7th is always a time for reflection for me, remember- ing as I do one William J Flood (distant relative, same name!) who commanded Wheeler Air Force Base, Pearl Harbor at 0756 on that date, in 1941. The real threat to his fighters was surely sabotage from the substantial Japanese population of Oahu, not air attack. So he pushed all the planes very close together for easy guarding. But, just in case, let us make sure that some are fully fuelled and armed. Like MMC, this probably seemed like a good idea at the time. Experimenting with what was then a novelty, a US made radar set, the two operators were baffled to pick up their first ever return, but a signal so big it was almost faulty. Their shift finished at 0800 anyway. We have all done it. We set up sophisticated screening systems and then switch off the irritating alarm when it does finally go off (anaesthetists, take note). Our patient charts must now carry traffic light col- ours to remind the FTSTAZ locum (I have met such a creature) that the pulseless patient is at risk.

The RSM last Friday! A fine suggestion from the Otology Section President way back in January was ‘What I Learn from the Journals’. Then I saw my topic—Chronic Otitis Externa! Never...