Proposed ORL UEMS GUIDELINES in surgical procedures

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GUIDELINES

information intended to advise people on how something should be done or what something should be

http://dictionary.cambridge.org/
Clinical Practice Guidelines

The UEMS ORL Section and Board have proposed a set of draft guidelines for various surgical procedures and these are now published on the UEMS ORL Section website. The guidelines indicate a definition of the operative procedure, indications, and pre-surgical assessment. The operative technique used. There is a section for patient information and informed consent, and finally, outcome measures by which the procedures can be assessed.

These guidelines represent a broad overview and may provide a framework for revision by national associations to provide guidelines appropriate for individual European countries.

Richard Szmek, M.D., F.A.C.S.
Secretary General, Service & Board of Otolaryngology

- Adenoidectomy-Lowlaryngotomy
- Anterior rhinological procedures
- Inferior turbinectomy
- Laryngectomy
- Middle Meatal antrostomy
- Myringoplasty
- Nasal polyectomy
- Parotidectomy
- Septectomy
- Tongueectomy
- Ventilation tube insertion

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1. Adenoidectomy – Adenoidotomy
2. Annexe Rhinology Procedures
3. Inferior Turbinectomy
4. Laryngectomy
5. Middle meatal antrostomy
6. Nasal polipectomy
7. Parotidectomy
8. Septoplasty
9. Tonsillectomy
10. Ventilation Tubes insertion
10.15 Introduction of main topic.
THE CURRENT STATE OF ORL OPERATIONS IN THE E.U. WHERE ARE WE NOW?
Indications, patient information and outcome measures for ORL operations

**Mr. Maw**

Mr. Richard Maw, Secretary General of UEMS ORL Section and Board introduces the main topic and explains the division done into the four working groups.

**Group A:** Ventilation tube insertion and tonsillectomy  
**Chairman:** Francis Marchal  
**Scribe:** Malou Hultcrantz

**Group B:** Septal surgery, endoscopic sinus surgery/ ethmoidecomy and sterilisation of endoscopic equipment  
**Chairman:** Jean Michel Klossek  
**Scribe:** Michael Walsh

**Group C:** Adenoidectomy and myringoplasty  
**Chairman:** Sten Hellstrom  
**Scribe:** David Proops

**Group D:** Parotidectomy and laryngecctomy.  
**Chairman:** Eberhard Stennert  
**Scribe:** Gert-Jan Hordijk
ADENOIDECTOMY/ADENOIDOTOMY

1. Definition:
   Removal of lymphoid tissue from nasopharynx

2. Indications:
   1. Symptomatic adenoids
   2. Nasal obstruction
   3. Snoring
   4. Ear symptoms
   5. Recurrent URTI
   6. Associated speech problems

3. Pre-operative Assessment

4. Method/Operative Technique
   1. GA
   2. Access: tonsil position, tonsil gag
   3. Inspection
   4. Appropriate instrumentation
   5. Haemostasis
   6. Postoperative management: observation, recordings and analgesia

5. Information/Consent
   1. Written (recommended)
   2. Individualised (recommended)
   3. Signed (recommended by patient and doctor)
   4. Informed (recommended written documentation)

   Complications
   1. Bleeding
   2. Anaesthesia
   3. Rhinolalia aperta
   4. Aspiration
   5. Torticollis
   6. Dental problems
   7. Special risk patients i.e. (Down’s (atlanto-occipital dislocation)

6. Outcome Measures
   1. Subjective relief of symptoms
   2. Objective: none
LARYNGECTOMY

1. **Definition:** Complete removal of the larynx. A complete separation of the digestive tract and the respiratory tract is the result.

2. **Indications:**
   - Primary or secondary malignant tumours arising in the larynx or neighbourhood where larynx preservation is not a therapeutic option (e.g., advanced squamous cell carcinoma T3, T4; advanced non-epithelial malignancies, metastasis, etc.)
   - Others: space occupying, obstructing lesions (osteomas, chondroma, myoma etc.)
   - Trauma (e.g., severe persistent obstruction of airways, severe persistent aspiration)
   - Chronic aspiration (e.g., stroke, other neurological disease, necrosis of laryngeal framework, e.g., radiation, infection)

3. **Pre-operative assessment:**
   - **Institutional requirements:**
     - Multidisciplinary management (ENT-HNS, Oncology, Radiology, voice and psychosocial rehabilitation etc.)
     - ICU
     - Professional expertise (subspeciality postgraduate training, adequate workload)

4. **Method/Operative Techniques:**
   - Technique of tracheotomy: skin incision, nubbing of hypopharynx, +I- neck dissection
   - Type of voice prosthesis (primary or secondary voice rehabilitation)
     - Wound drainage
     - Antibiotics, analgesics
     - Post-operative ICU (Intensive care unit)
     - Duration of hospitalization
     - Insertion of feeding tube or PEG
     - Duration of parental nutrition

5. **Information/Consent:**
   - Description of the surgical procedure
     - Alternative therapeutic strategies (organ preservation, prognosis)
     - Complications (inter or post-operative bleeding, need of blood transfusion, haemorrhage, sepsis, salivary fistula, respiratory and wound infection, dysphagia, aphagia, aspiration, stenosis, clavicle displacement)
     - Sequelae (permanent tracheotomy, change or loss of speech ability, smell, taste, laughter, weight lifting, cosmetic changes, etc.)
     - Rehabilitation (speech, swallowing, psycho-social, occupational)
     - Patient support group

6. **Outcome Measures:**
   - Case of the disease - survival
   - Quality of life (speech and swallowing rehabilitation, psychosocial rehabilitation, employment, cosmetic results)
   - Complications (wound infections, salivary fistula, hypopharyngeal stenosis etc.)
   - Availability of technical devices and support
ANNEXE TO THE RHINOLOGICAL GUIDELINES

It was agreed that all patients should be given a written Information Sheet at the time of obtaining Consent whether written or verbal. This Information Sheet should:

- Outline the definition and goals of surgery.
- The alternative treatments other than surgery.
- It should also outline the morbidity associated with the operation.
- The operative risks including those occurring in the immediate period and delayed risks should be outlined.

It should be emphasised to the patients that risks have to be stratified, that is, if they have complex systemic disease or recurrent disease, the risks of surgery are greater.

It was agreed that in Academic Centres the patient should be informed that the operation maybe carried out by a Trainee under supervision of the Surgeon.

All patients should be given an agreed simple questionnaire both pre-operative and post-operatively. This is to allow for validation of procedures and as quality control in accumulating evidence-based information.

The majority of rhinological operations should be only performed after a trial of medical therapy and in all cases patients should be warned that recurrence of disease is likely especially if they have a systemic disease that predisposes to recurrence such as allergy, aspirin sensitivity, asthma or cystic fibrosis.

All patients prior to rhinological procedures should have nose-endoscopy, a trial of decongestant therapy in the clinic to assess the extent of mucosal disease and a validated pre and post-operative questionnaire. Rhinomanometry is not routinely indicated, as it has not yet scientifically been proven to be universally accepted as a routine pre-operative and post-operative assessment tool. Imaging is recommended? Mandatory? especially when extensive surgery is decided.
09.30 – 09.45 Clinical practice guidelines. Update before going to web

Mr. Richard Maw

Richard Maw shows the documents that came up from last years meeting in Nice and asks all chairmen and scribes to review them and send them to Maria and once this is done they will go up on the web.

David Proops asks if it will be worth adding evidence based information to the procedures. Richard Maw replies that it will be very interesting but difficult to do by email; it may well have to be a topic for a future meeting.

It was said that these documents should be agreed by National Societies and then a harmonized document should be finalized and on the web.

Bernard Maillet says that the UEMS is coming to an agreement with GIN (Guideline International Net) to do this kind of work and therefore this Section is a bit ahead with this.

It is concluded that the document should be send to all delegates and Sub-specialty ORL European Organizations to complete the blank areas in the document and to agree with guidelines. They should send their comments back to Maria de la Mota by the 30th December 2005.
Welcome

Welcome to the Guidelines International Network. We hope you like our website and find it easy to navigate, as well as informative. Our vision has been to make the website technically responsive on all devices as well as easy to navigate, but most importantly to facilitate communication, engagement and collaboration with and amongst our members.

The website is here for you, so please use it and give us feedback – we want to hear of ways to make it even better for you. There are lots of new features, so please take a look at: “Have your say” – a new moderated blog, where the topic will change monthly; the Project/Collaboration board where new projects and working groups will seek volunteers, as well as the areas for the new working groups and regional communities along with their discussion boards.

What we do

Our mission is to lead, strengthen and support collaboration in guideline development, adaptation and implementation. As a major player on the global healthcare quality stage, G-I-N facilitates networking, promotes excellence and helps our members create high quality clinical practice guidelines that foster safe and effective patient care.

Our networking role is enhanced through annual conferences, region-specific communities and topic-specific working groups in which participants exchange knowledge and improve methodology. We welcome your participation in our vibrant community and are delighted to share, through this web portal, a wide variety of support tools and publications to enhance guideline development and knowledge transfer.
Query: Tonsillectomy

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Page last updated: Sep 11, 2015
How Following the Standard of Care Can Get You Sued

Neil Chessnow

Disclosures | March 27, 2015

Why "Choosing Wisely" Won't Protect You in a Lawsuit

Many doctors believe that following the standard of care in treating patients is enough protection against a lawsuit for medical malpractice. Not so, as a recent Medscape article by an emergency physician and attorney pointed out.

"Although guidelines may help guide diagnosis and treatment of disease, their use is not limited to clinical purposes," the author wrote. "Guidelines may also be used by insurance companies to approve or deny payment. The nuances in the underlying purpose of guidelines highlight the importance of examining the intent of guidelines before offering them as evidence in a medical malpractice case."

The article examined payment guidelines issued by insurers, including Medicare and Medicaid; clinical practice guidelines issued by specialty societies, of which there are more than 2500 related to diseases and thousands more related to treatment of disease; practice guidelines arising from the Choosing Wisely® initiative; the validity of quality indicators issued by the Centers for Medicare & Medicaid Services for hospitals; and "safe harbors," legislative guidelines created to protect practitioners from lawsuits.

In each instance, adhering to the guidelines could help a doctor’s case or doom it, depending on the facts and their situational context. The author concluded, "The most judicious use of guidelines is to treat them as general outlines subject to change as our knowledge of medicine evolves, rather than as strict directives of medical practice."
"The most judicious use of guidelines is to treat them as general outlines subject to change as our knowledge of medicine evolves, rather than as strict directives of medical diagnosis and management."

Neil Chesanow
WHAT SHALL WE DO?

- Update
- Extend
- Modify
- Delete
MEN to the left because WOMEN are always right!
If You want to go fast, go alone
If You want to go far, go together

*African Proverb*
THANK YOU, SO MUCH.

WILL MISS YOU, SO MUCH.